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Jake Linford

jlinford@law.fsu.edu

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THE KIDNEY DONOR SCHOLARSHIP ACT: HOW COLLEGE SCHOLARSHIPS CAN PROVIDE FINANCIAL INCENTIVES FOR KIDNEY DONATION WHILE PRESERVING ALTRUISTIC MEANING

JAKE LINFORD*

I. INTRODUCTION

When I was a child, my father sold several hundred acres of property, some of it to the local county government, and some of it to a company that mines phosphate. After I graduated from college, I remember walking with Dad through one of these parcels of property that he no longer owned, located directly behind his house. The property had been in our family for three generations, and I viewed it as part of an inviolable whole. I remarked that it was sad to think that this property was no longer in our family. He bristled at the statement, and offered the following rejoinder: “that property put you through school.”

I reflected then that my affection for the property was not stronger than my attachment to and dependence on my undergraduate degree and the opportunities that it afforded me. When viewed through the lens of my emotional attachment to the property as a symbol of our family, it seemed invaluable, in the sense of something to which a price should not be attached. When I looked at the property through the lens of the opportunities it afforded, it took on a different meaning—it became a symbol of my father’s sacrifice to meet his children’s needs. The property was no longer “invaluable,” while the education its sale had enabled had become so.

I contrast this story with one of meaningless loss, also from my father’s life. When Dad was fifteen years old, he was injured while riding an inflated inner tube down a snowy hill. The accident damaged his kidney, which had

* B.A. 1996, University of Utah; J.D. 2008, The University of Chicago. The author would like to thank his family, Jenny, Thelonious, Ellington, and Gillespie for their support during the writing process. In addition, the author would like to thank Professor Michele Bratcher Goodwin for her boundless enthusiasm, support, and encouragement, Professor Lisa Bernstein and the University of Chicago Legal Scholarship Workshop for excellent feedback and incisive critiques, and Ron Lundeen, Stephanie Lundeen, Lilit Voskanyan, and Nevin Gewertz for their generosity in reading and commenting on earlier drafts of this article.

to be removed. For the past forty-two years, Dad has lived with one kidney. The loss of the kidney has not seriously impacted his health. In fact, he played for the Wyoming High School Class A state championship basketball team during his senior year. There is no symbolism attached to Dad's lost kidney, other than the lesson that inner tubes are not a safe mode of transportation down snowy hills.

I saw a connection between these stories as I considered the shortfall in the supply of transplantable kidneys in the United States. The current procurement regime cannot meet the need for kidneys, and the burden of these shortages falls disproportionately on people of color. In 2006, approximately 4,400 people died while waiting for a kidney.¹ On average, a Black person waits nearly twice as long for a kidney as a White person.² The status quo is unacceptable both on moral and economic grounds. Those who wait for a donated kidney are relegated to a limbo of dialysis, cut off from many productive endeavors. In addition to the personal losses, the economic costs of dialysis are also significant.

The kidney shortfall has inspired intense discussion regarding how best to address shortages in an equitable and ethical manner.³ Two prominent scholars highlight the seemingly unconquerable gulf between two theoretical poles. Dr. Arthur Matas, a prominent transplant surgeon, argues that "barring kidney sales is tantamount to sentencing some patients to death."⁴ Dr. Francis Delmonico, a Harvard University professor of medicine—and, until recently, the president of the United Network for Organ Sharing (UNOS)—fears a system of commodification would exploit poor, vulnerable, and unhealthy populations, and cause altruistic donation to "wither away."⁵

This article responds to a challenge issued by Michele Goodwin to bridge the gulf between these theoretical poles by moving from a discussion of whether or not to commodify to a discussion of what degree of commodification might be acceptable.⁶ The question that remains in the

1. Laura Meckler, *How Much Is that Kidney in the Window?: A Radical Idea Goes Mainstream—Selling Human Organs*, CHI. SUN-TIMES, Nov. 25, 2007, at 1B.

2. MICHELE GOODWIN, BLACK MARKETS: THE SUPPLY AND DEMAND OF BODY PARTS 45 (2006) [hereinafter GOODWIN, BLACK MARKETS] (reporting that in 2003, Blacks waited an average of 1,891 days compared to 840 days for Whites).

3. See, e.g., Rob Stein, *States Revising Organ-Donation Law: Critics Fear Measure May Not Go Far Enough to Protect Donors*, WASH. POST, Apr. 9, 2007, at A1.

4. Meckler, *supra* note 1.

5. *Id.*

6. Michele Goodwin, *Private Ordering and Intimate Spaces: Why the Ability to Negotiate is Non-Negotiable*, 105 MICH. L. REV. 1367, 1369, 1384 (2007) [hereinafter Goodwin, *Private Ordering*] (arguing that until society begins discussing what degree of commodification is socially acceptable, organ donation regimes are unlikely to fully incorporate all members of society).

breach between these positions is whether a limited or regulated system of commodification—what scholars have referred to as “rewarded gifting” as distinguishable from “rampant commercialism”⁷—might increase the supply of transplantable kidneys while preserving altruistic giving and protecting potentially vulnerable populations from exploitation. This article proposes an academic scholarship incentive⁸ for living kidney donors as a means of addressing the shortage of kidneys in a way that protects the best aspects of the current altruistic regime.⁹ While a scholarship incentive has been mentioned as a way of incentivizing increased donation,¹⁰ this article is the first to seriously examine whether a scholarship incentive could be capable of preserving altruistic giving while reducing the current shortfall in kidney procurement.

The scholarship program envisioned would provide tuition, fees, and living expenses at a four-year university or a job-training program to which the donor-scholar qualifies for admission. The program would be limited to participants age eighteen or older. The program’s informed consent requirements will mirror those currently in use at organ transplant centers, and all information necessary to insure donor capacity to provide informed consent would be communicated to the donor-scholar only after the donor-scholar reaches the age of eighteen. Finally, each donor-scholar would have access to a health care professional unaffiliated with a recipient group and would have access to aftercare provided by the program.

This article identifies four problems with the current system for procuring kidneys, and argues in Part II that a scholarship incentive for living donors should provide positive solutions for each problem area. First, any system of commodification must address the effect of commodification on altruistic giving.¹¹ Altruism purists hold that altruistic giving will wither in the presence of a market system, and that there will be a resulting net loss in kidneys procured for donation. This article addresses the concern that a commodification regime will necessarily lead to a drop off in altruistic

7. A.S. Daar, *Rewarded Gifting and Rampant Commercialism in Perspective: Is There a Difference?*, in *ORGAN REPLACEMENT THERAPY: ETHICS, JUSTICE, COMMERCE* 181, 182 (Walter Land & John B. Dossetor eds., 1991).

8. This article will look primarily at the implications of an academic scholarship to a four-year institution. The program could easily be adapted to job training in a variety of nonacademic settings, an option also provided for soldiers under the G.I. Bill.

9. While the scholarship program could work equally well for the donation of a lobe of liver, for the sake of simplicity, the article deliberately limits the discussion to a kidney scholarship.

10. Michele Goodwin, *The Body Market: Race Politics & Private Ordering*, 49 ARIZ. L. REV. 599, 617 (2007) [hereinafter Goodwin, *The Body Market*].

11. See *id.* at 632-33 (noting the current debate among scholars regarding the effect of developing a framework that advocates organ commodification while preserving altruism).

donations by reviewing a series of attitudinal surveys which suggest that the less an incentive resembles a direct payment, the more palatable it becomes to society in general, and the more likely it is to increase, rather than decrease, the supply of kidneys suitable for transplant. Second, living donation can ameliorate some of the logistical issues created by relying on deceased donation.¹² Third, contrary to the presumptions of some academics, a system of living donation should reduce the incidence of diseased kidneys procured for transplant. Finally, the scholarship program can and should be structured to reduce the current racial imbalance experienced on organ waitlists.

The article then addresses arguments frequently raised against commodification and argues that the proposed scholarship incentive can effectively respond to these arguments. In Part III, the article explains how the scholarship incentive as conceived occupies a rhetorical position which suggests that it presents an acceptable mode of rewarded gifting. Because scholarships are understood as manifestations of altruism, the scholarship incentive can be designed to preserve spaces where altruistic giving will be both desirable and essential. This Part also analyzes ethnographies of altruists, including kidney and liver donors, to argue that the "fragility" of altruism suggested by some authors is more imagined than real. An examination of the nature of altruistic giving suggests that donors currently willing to donate under the exclusively altruistic regime will not be discouraged from donation by a regime of rewarded gifting like the scholarship incentive.

In Part IV, the article addresses issues of coercion. Critics assert that the commodification of kidneys threatens to coerce the participation of poor and underprivileged populations, even when donation is not in the best interest of the potential donor. These critics ignore the coercive pressures already present in the current allocation regime, which pushes American need for kidneys into foreign markets where American law cannot effectively reach to protect underprivileged donor populations. While a raw cash-for-kidneys regime might create problematic coercive pressure, the proposed scholarship incentive can mitigate the coercive power of commodification. Research into brain morphology and decisional heuristics suggests that the delayed nature of the proposed scholarship incentive will protect the decisional capacity of donor populations in a way that an upfront cash payment cannot. Part IV concludes by arguing that members of the

12. This article uses the term *deceased donation* throughout as a blanket term to indicate two types of cadaveric donations: those contemplated by the donor before death and committed to through a method like a donor card, and those where the family makes a decision at the time of death to donate a deceased donor's kidneys without any indication that donation was the donor's desire.

emerging adult population—individuals aged 18 to 25—have sufficient decisional capacity to make informed choices about whether to donate, and that the scholarship program would not impair that capacity.

Finally, in Part V, the article discusses the obstacles to the scholarship proposal embedded in the current statutory regime, and argues that the treatment of athletic scholarships provides a workable analogy for the proposed scholarship incentive for kidney donation. The article then concludes by suggesting a more directed study of public attitudes towards a hypothetical scholarship, and eventually, a pilot scholarship program, allowing society to measure whether the potential benefits suggested in this article can be realized.

II. PROBLEMS WITH THE CURRENT ORGAN PROCUREMENT PROCESS

Measurable economic benefits would result from reducing the number of patients on dialysis and the scholarship incentive can provide commensurate economic benefits to the recipients of higher education. The first problem with the current system of kidney procurement and allocation is that there are simply not enough kidneys to meet the demand.

A. Lack of Kidneys

In 2008, 4,410 persons died while waiting for a transplantable kidney.¹³ There were 79,749 potential recipients waiting for a kidney on May 11, 2009, and approximately 74,000 in 2007.¹⁴ In 2008, there were 16,517 donor kidneys recovered: 5,967 kidneys from living donors, and 10,500 kidneys from deceased donors.¹⁵ Need outstripped supply by roughly 57,000 kidneys in 2007, and that gap grows each year. Those waiting for kidneys are usually consigned to dialysis as a stopgap measure of preserving their lives by mechanically executing part of the cleaning function that healthy kidneys provide. Dialysis is a measure so unattractive that some Americans with the financial wherewithal avoid the wait by going to foreign

13. ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, NATIONAL DATA, at www.optn.org/latestData/step2.asp? (choose "Waiting List Removals" and "Kidney," then select "Death Removals by State by Year") (last visited Apr. 9, 2009) (referring to the chart "All States" under the year "2007"). The data contained on OPTN's website is updated on a daily basis and subject to change based on future data submissions or corrections. *Id.*

14. ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, DATA, at www.optn.org/data/ (last visited May 11, 2009) ("Waiting List Candidates as of Today - Kidney").

15. ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, NATIONAL DATA, at www.optn.org/latestData/step2.asp? (choose "Transplant," select "Kidney," then choose "Deceased Donor Transplants in the U.S. by State," and "Deceased Donors Recovered in the U.S. by Donor Age") (last visited Apr. 9, 2009).

countries. Unfortunately, the residents of those countries are potentially more vulnerable to predation by the unscrupulous and criminal.¹⁶

Dialysis costs between \$60,000 and \$90,000 per year.¹⁷ The average life span of a patient on dialysis is five years,¹⁸ thus, unless a donor kidney is located, the average cost of dialysis per patient is approximately \$372,000.¹⁹ The estimated cost of transplant surgery, and five years of the immunosuppressant drugs necessary to keep the recipient's body from rejecting the new kidney, is approximately \$124,000.²⁰ The rough net savings over the five-year period is \$248,000, or \$49,600 per year.

That simple economic picture doesn't take into account the quality of life costs of dialysis. Scholars estimate that the social welfare costs of dialysis are over \$1 billion; "many (or most) of those patients experience energy loss, nausea, weakness, hypertension, bone disease, infections, atherosclerotic disease, and other problems that emanate from the treatment itself."²¹ Those numbers do not take into account the physical and emotional toll on patients, many of whom cannot work,²² and who as a group are twice as likely as non-dialysis patients to commit suicide.²³

It is difficult to argue against the benefits of getting patients off dialysis and back to a normal life by providing a kidney. Herein lays the basic proposal of this article: offer educational scholarships as an incentive to those who make a living donation of a kidney.²⁴ If handled correctly, the

16. See, e.g., Karen Russo, *U.S. Couple in Kidney Racket Claims Ignorance: India Will Detain N.Y. Pair Until They Provide Information on Shady Enterprise*, ABC NEWS, Jan. 30, 2008, at <http://abcnews.go.com/Health/Story?id=4217154&page=1> (last visited Apr. 9, 2009) (reporting that an American couple was detained by Indian authorities for using the services of an illegal kidney racket whereby donors were forced to donate at gunpoint).

17. See Betsy Rogers, *Goodnight, Dialysis*, WASH. U. IN ST. LOUIS SCHOOL OF MED. OUTLOOK, at <http://outlook.wustl.edu/summer2002/dialysis.html> (last visited Apr. 9, 2009) (noting that in-center dialysis costs \$70,000 a year); Goodwin, *The Body Market*, *supra* note 10, at 634.

18. Sahar Kajbaf, Graham Nichol & Deborah Zimmerman, *Cancer Screening and Life Expectancy of Canadian Patients with Kidney Failure*, 17 NEPHROLOGY DIALYSIS TRANSPLANTATION 1786, 1786 (2002).

19. Arthur J. Matas & Mark Schnitzler, *Payment for Living Donor (Vendor) Kidneys: A Cost-Effectiveness Analysis*, 4 AM. J. TRANSPLANTATION 216, 218 (2003).

20. *Id.* at 218 tbl.1 (illustrating an estimated cost of \$72,693 for the first year after transplantation and \$12,814 for maintenance the following two years thereafter).

21. DAVID L. KASERMAN & A.H. BARNETT, *THE U.S. ORGAN PROCUREMENT SYSTEM: A PRESCRIPTION FOR REFORM* 35, 68 (2002).

22. *Id.* at 35.

23. Lloyd R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market*, 58 GEO. WASH. L. REV. 1, 37-38 n.110 (1989).

24. While the program could also provide a scholarship to the family of a donor who commits to deceased donation in case of accident, this article deals primarily with the benefits

scholarship program could encourage sufficient donation to meet the current need, as well as provide a sustainable supply of kidneys for future needs. The average cost of tuition at a four-year private institution was \$29,307 for the 2007-2008 academic year.²⁵ In-state tuition at a state college is significantly more affordable.²⁶ The savings of transplantation over dialysis could easily pay that amount and still provide substantial savings to the party (generally Medicaid) that would originally have been obligated to pay for dialysis.

To briefly outline the important features of the program: the scholarship incentive would pay tuition, fees, and housing for students who make a living donation of a kidney. The program would not qualify a particular donor for a particular school, but would pay for educational expenses at a college, university, or trade school that has accepted the donor.

The program would be limited to students eighteen years of age or older. All medical information necessary to meet informed consent requirements must be provided after the donor has reached eighteen years of age. Donors would receive consultation with a nephrologist unconnected with the recipient's transplant team to assure that there is no undue pressure to complete the donation process. All donors would receive comprehensive psychological screening, as well as screening regarding family support structure and general health. Potential donors who are considered a poor match for donation due to psychological, health or other factors will not be selected for the program. However, evaluating physicians would not consider an interest in the educational scholarship grounds to find a donor unfit.

B. *Could Scholarships Help?*

The scholarship program will only be worth the effort if it will increase the net supply of kidneys available for transplant. This requires more than simply encouraging donors to donate, but requires some evidence that a financial incentive like a scholarship will not discourage the altruism that fuels the current procurement system. Several scholars argue that it is unlikely that any incentive program will produce a net increase in kidney

of living donation. As discussed in Part II.C and D *infra*, there are logistical reasons to think that living donation is preferable to deceased donation.

25. NAT'L CTR. FOR EDUC. STATISTICS, INST. OF EDUC. SCI., MINI-DIGEST OF EDUCATION STATISTICS 2008, at 53 (2009), available at <http://nces.ed.gov/pubs2009/2009021.pdf> (last visited Apr. 9, 2009).

26. The average cost of in-state tuition at four-year public institutions for the 2007-2008 academic year was \$12,944. *Id.*

donation.²⁷ It is difficult to demonstrate empirically that any program of commodification will encourage Americans to donate, although there is some evidence that citizens of foreign countries who are economically desperate will donate a kidney, often for what Americans would consider to be minimal compensation.²⁸ This part of the article reviews a number of attitudinal surveys conducted among various groups. The overview of these studies suggests that the correct incentive program could produce a net increase in donation. These studies also suggest that incentives which are structured more like a reciprocal gift and less like a direct market transaction are viewed more favorably by both the general public and by groups more directly related to the procurement process. This article also recognizes the general limit of attitudinal studies. While scholars have found a limited correlation between what respondents say they will do in a hypothetical situation and what they decide when faced with an actual decision,²⁹ "attitudes are not synonymous with behavior."³⁰ A second limit presented by the attitudinal studies reviewed is that the majority of them inquire into attitudes regarding deceased donation, and thus may have limited descriptive power in predicting responses to an incentive for living donation like the proposed scholarship program. Finally, only one study offers the option of a scholarship incentive to respondents, and that study fails to provide any details regarding the percentage of respondents favorably disposed.³¹

27. See, e.g., Jeffrey M. Prottas, *Buying Human Organs—Evidence That Money Doesn't Change Everything*, 53 *TRANSPLANTATION* 1371, 1371 (1992) (reporting on the results of a 1986 attitudinal study in which seventy-eight percent of "those surveyed reject the idea that families of donors ought to be paid for granting permission" to have organs donated).

28. Madhav Goyal et al., *Economic and Health Consequences of Selling a Kidney in India*, 288 *JAMA* 1589, 1590, 1591 (2002) (reporting that 305 residents of Chennai, India, received an average of \$1,070 for selling one kidney). It should be noted, however, that this amount is more than the average yearly income in India of \$950. See The World Bank, *India at a Glance*, available at http://devdata.worldbank.org/AAG/ind_aag.pdf (last visited Apr. 9, 2009) (reporting that in India the average yearly income in 2007 was \$950).

29. See Monica A. Landolt et al., *They Talk the Talk: Surveying Attitudes and Judging Behavior About Living Anonymous Kidney Donation*, 76 *TRANSPLANTATION* 1437, 1437-38 (2003) (citing two broad reviews of psychological literature which find a limited correlation between individuals' reported intentions and their actual behaviors).

30. Stephen J. Kraus, *Attitudes and the Prediction of Behavior: A Meta-Analysis of the Empirical Literature*, 21 *PERSONALITY & SOC. PSYCHOL. BULL.* 58, 71 (1995).

31. Raymond L. Horton & Patricia J. Horton, *Improving the Current System for Supplying Organs for Transplantation*, 18 *J. HEALTH POL. POL'Y & L.* 175, 177-78 & n.2 (1993) (reporting—without providing details—that in a study of 465 adults in an unspecified "local community," both the general respondent population and registered organ donors favored an option where organ donors would be provided with "a voucher that could be used for college tuition or job training of heirs" over a cash incentive).

The attitudinal studies reviewed break down into several categories. The largest category is comprised of nine separate attitudinal studies where respondents were randomly selected from the general population. In five of these studies, respondents indicated that incentives that were in-kind (like a payment toward unpaid, uninsured medical expenses) or non-monetary (like donor recognition or priority placement on the organ waitlist) were generally better received than monetary incentives (like cash in exchange for donating a kidney).³²

A smaller pilot study by John H. Evans³³ concluded that the type of incentive matters in the realm of kidney donation because when it comes to

32. See Leonieke Kranenberg et al., *Public Survey of Financial Incentives for Kidney Donation*, 23 NEPHROLOGY DIALYSIS TRANSPLANTATION 1039, 1040 tbl.1, 1041 (2007) (reporting, from an internet questionnaire of 550 paid Dutch respondents, that while financial incentives for kidney donations were generally viewed unfavorably on a five-point Likert scale—46.6% of respondents rated them unfavorably or very unfavorably, compared with 25% that rated them favorably or very favorably—respondents who responded positively to incentives favored lifetime health insurance (66.2%) over a lump-sum cash payment to donors (33.8%)); J.D. Jasper et al., *The Public's Attitudes Toward Incentives for Organ Donation*, 31 TRANSPLANTATION PROC. 2181, 2181-82 (1999) (reporting in a study of 300 prospective jurors at a county courthouse in Philadelphia, Pennsylvania, who served as respondents in exchange for a candy bar, that “[p]olicies offering in-kind incentives (e.g., a \$1,500 payment toward unpaid, uninsured medical expenses) or nonmonetary incentives (e.g., donor recognition) were generally considered more appropriate than policies offering monetary incentives (e.g., \$1,500 in cash).”); T.J. Cossé et al., *Public Feelings About Financial Incentives for Donation and Concern About Incurring Expenses Due to Donation in One US City*, 29 TRANSPLANTATION PROC. 3263, 3263 (1997) (reporting that in a three year telephone survey of adults in the metro Richmond, Virginia area, more respondents favored a contribution to funeral expenses for the families of deceased donors (thirty-five percent agreed or strongly agreed on a 5-point Likert-type scale in 1994; thirty-five percent in 1995; and forty-percent in 1996) than favored a cash payment to families making a donation of a deceased relative’s organs (thirty-two percent agreed or strongly agreed in 1994; twenty-six percent in 1995; and thirty percent in 1996)); Thomas G. Peters et al., *Organ Donors and Nondonors: An American Dilemma*, 156 ARCHIVES INTERNAL MED. 2419, 2421 tbl.2 (1996) (reporting results of a 1992 telephone survey of randomly selected respondents conducted by UNOS, where respondents indicated that they were very interested or somewhat interested in the following incentive options: (1) preferred donor status (fifty-nine percent); (2) \$2,000 toward funeral expenses (fifty-four percent); (3) \$2,000 charitable contribution (fifty-two percent); (4) limited life insurance (forty-six percent); and (5) \$2,000 cash payment (thirty-five percent)). The Peters survey also reports that younger respondents were most favorably disposed towards the cash incentive of any age group (fifty-three percent of respondents aged eighteen to twenty-four indicated they were very interested or somewhat interested in the cash incentive, compared with thirty-five percent of respondents overall). *Id.* at 2421 tbl.2.

33. John H. Evans, *Commodifying Life? A Pilot Study of Opinions Regarding Financial Incentives for Organ Donation*, 28 J. HEALTH POL. POL’Y & L. 1003, 1010-14 (2003) (measuring the responses of eighty-six students in a graduate level health policy class to a variety of end-of-life vignettes where respondents must rate on a ten point scale—where one is “absolutely not” and ten is “absolutely”—whether a hypothetical family should terminate life

commodifying the products of the body, “a dollar is not a dollar . . . [and] [p]eople tend to consider dollars that circulate within the same institutional sphere to have the same moral status.”³⁴

Other general population attitudinal studies report a general favorable response to incentives for organ donation in the abstract.³⁵ Two Gallup polls, the first taken in 1993³⁶ and the second in 2005,³⁷ indicate an increasing willingness on the part of survey respondents to consent to

support for a family member, and the family is faced with one of four hypothetical incentives: (1) \$2,000 for funeral expenses; (2) a \$25,000 voucher for the patient’s medical expenses; (3) \$25,000 in cash for the family to use as they wish; or (4) the altruistic status quo). Evans reports a positive correlation between a variable in the vignettes increasing amounts of medical debt for the family with an increased strength of recommendation that the family terminate life support. *Id.* at 1019 (stating, based on the correlation between a growing debt variable and the recommendation to end life, that “[h]aving a health care system where people ultimately are responsible for their bills is enough to make people evaluate the price of keeping someone alive.”). Evans found that the \$25,000 cash incentive does not encourage respondents to recommend ending life support, but that the two voucher plans actually increased the frequency with which respondents indicated that the family should not terminate life support. *Id.* at 1019-20. Evans found a statistically significant negative correlation between increasing debt and the health insurance voucher, which he concludes indicates a discounting of the debt when presented with the medical bill voucher, but not for the other incentives. *Id.* at 1021-22.

34. *Id.* at 1022 (internal citations omitted). Evans concludes that the medical bill voucher is commensurate, or from the same sphere as the mounting debt from medical bills, and that there is not a statistically significant correlation between cash payments or funeral vouchers and the debt variable because they provide “fungibility outside of the medical sphere.” *Id.* at 1022. Evans also posits that “equating the surgical removal of organs with an object outside of the medical sphere—such as the college education the family could buy with the \$25,000 hypothetical payment—violates our sense of the sacredness of these institutional boundaries.” *Id.* Evans’s study does not measure responses to a scholarship voucher, and it is unclear whether responses would be different were the respondents considering vignettes regarding a decision to make a living donation of a kidney.

35. See A. Guttman & R.D. Guttman, *Sale of Kidneys for Transplantation: Attitudes of the Health-Care Profession and the Public*, 24 TRANSPLANTATION PROC. 2108, 2108 (1992) (reporting that members of the Canadian public and medical profession interviewed reported that forty percent of respondents indicated that a hypothetical dialysis patient of Canadian heritage should be allowed to purchase a kidney, while forty-nine percent indicated that a hypothetical patient of Indian heritage should be able to buy a kidney).

36. THE GALLUP ORG., INC. FOR THE PARTNERSHIP FOR ORGAN DONATION, BOSTON, MASSACHUSETTS, *THE AMERICAN PUBLIC’S ATTITUDES TOWARD ORGAN DONATION AND TRANSPLANTATION: A SURVEY* (1993) [hereinafter GALLUP 1993].

37. THE GALLUP ORG. FOR THE DIVISION OF TRANSPLANTATION HEALTH RESOURCES AND SERVICES ADMIN., 2005 NATIONAL SURVEY OF ORGAN AND TISSUE DONATION ATTITUDES AND BEHAVIORS 3-4 & tbl. 1 (2005), available at <ftp://ftp.hrsa.gov/organdonor/survey2005.pdf> (last visited Apr. 9, 2009) [hereinafter GALLUP 2005] (reporting in tbl.1 the results of 2,341 telephone interviews measuring the attitudes of the public regarding organ donation).

donate their organs³⁸ or the organs of a deceased family member³⁹ if offered a financial incentive. The 2005 Gallup poll also indicated an apparent polarization, with more respondents indicating that financial incentives would make them less likely to donate increasing over time (8.9% reporting they were less likely to donate their own or a family member's organs in 2005 vs. 5% reporting they were less likely to donate their own organs and 8% indicating they were less likely to donate a family member's organs in 1993).⁴⁰ The Gallup polls do not distinguish between types of financial incentives.

Two studies compare the attitudes of next-of-kin who chose to donate a deceased relative's organs with next-of-kin who were approached but chose not to donate. A study by James R. Rodrigue and his associates⁴¹ reports that next-of-kin donors contemplating a hypothetical generic financial incentive to encourage kidney donation indicate a slight decrease in their willingness to donate,⁴² while next-of-kin nondonors indicate a slight increase in the willingness to donate.⁴³ Rodrigue and his associates expressed some concern that financial incentives offered to next-of-kin were not likely to lead to increased deceased donation rates, but that they might well increase participation by donors themselves.⁴⁴ It should be noted, however, that the Rodrigue study did not distinguish between financial incentives, and that its ability to predict the response to a particular incentive is therefore limited. Laura Siminoff and Mary Beth Mercer also conducted a study of next-of-kin, finding moderate levels of approval for a variety of

38. In 2005, 16.6% of survey respondents indicated "they would be 'more likely' to donate their own organs if paid an incentive," an increase of 4.6% over a response to a similar question in the 1993 Gallup poll. *Id.* at iv, 23.

39. Respondents also indicated an increased willingness to donate a family member's organs upon death if provided with an incentive (reporting 18.7% in 2005 vs. 12.0% in 1993). *Id.* at 23.

40. *Id.* at 24 fig. 12 ("Financial Incentives and Deceased Organ Donation, 1993-2005").

41. James R. Rodrigue et al., *Attitudes Toward Financial Incentives, Donor Authorization, and Presumed Consent Among Next-of-Kin Who Consented vs. Refused Organ Donation*, 81 TRANSPLANTATION 1249, 1250-51 & tbl.1 (2006) (reporting the results of a telephone survey of 561 next-of-kin recently asked to consent to deceased donation of a family member's organs: 348 donors and 213 non-donors).

42. Among next-of-kin donors, 84.5% ($n = 294$) reported that the incentives would make no difference, while 6% ($21 / 344 = 6\%$) ($n = 21$) reported they would be more likely to donate, and 9.5% ($33 / 348 = 9.5\%$) ($n = 33$) reported they would be less likely to donate. *Id.* at 1252 tbl.2.

43. For next-of-kin non-donors, 67.6% ($n = 144$) reported no effect, while 19.2% ($41 / 213 = 19.2\%$) ($n = 41$) reported they were more likely to donate, and 13.1% ($28 / 213 = 13.1\%$) ($n = 28$) indicated they would be even less likely to donate. *Id.* at 1252 tbl.2.

44. *Id.* at 1254.

incentives.⁴⁵ The Siminoff study did not attempt to measure whether the donors' or non-donors' decisions would have changed in light of donation, but did ask respondents whether they would have been offended/insulted by an offer to pay funeral expenses, and found a limited negative reaction on the part of next-of-kin respondents.⁴⁶

Three other studies compare the responses of registered organ donors to the general population and reach decidedly mixed results. A 2001 study conducted by Dr. Cindy Bryce measured the response to specific programs providing financial benefits to the families of deceased donors.⁴⁷ The majority of respondents reported that benefits would have no effect on them.⁴⁸ For both registered organ donors and those not registered as donors, more respondents reported that financial incentives would increase the likelihood that they would donate than reported that financial incentives for their families would make them less likely to donate.⁴⁹ Consistent with the general population studies referenced above,⁵⁰ respondents were more comfortable with benefits which function more as reimbursements or as a means of offsetting the costs associated with the death of a loved one and

45. Laura A. Siminoff & Mary Beth Mercer, *Public Policy, Public Opinion, and Consent for Organ Donation*, 10 CAMBRIDGE Q. HEALTHCARE ETHICS 377, 377, 380 tbl.2 (2001) (reporting on a study of over 600 next-of-kin who had been asked to consent to organ donation from 400 related acute care patients, and the attitudes of the respondents regarding three incentives to encourage kidney donation: (1) "[f]amilies who agree to donate should be given money to pay for funeral expenses" (31.6% agree); (2) "[p]eople who have signed a donor card should receive an organ transplant before others do" (25.4% agree); and (3) "[t]he government should provide money to families who agree to donate organs" (22.2% agree)).

46. In response to the funeral benefit, 25% of respondents indicated they would not have been offended/insulted. *Id.* at 382 tbl.3 ("Families' Attitudes about Funeral Expense Incentive). 20.3% mentioned that they "[w]ould have appreciated the offer," and 23.8% indicated they would have been insulted. *Id.* Some respondents (16.9%) indicated a belief that other people might appreciate the offer. *Id.* A smaller percentage (17.4%) of the respondents—and perhaps an overlapping portion, although the study does not make this clear—indicated that "[o]rgan donation should not involve 'the selling of organs or be a business transaction[.]'" *Id.* 8.7% reported that "[f]inancial help for funeral expenses should not be offered[.]" *Id.*

47. C.L. Bryce et al., *Do Incentives Matter? Providing Benefits to Families of Organ Donors*, 5 AM. J. TRANSPLANTATION 2999, 3000-01 (2005) (reporting on the attitudes of 971 randomly sampled adults from Pennsylvania households asked to offer their opinions on incentives in general and to evaluate five specific programs on a 5-point Likert scale, ordered here from the most to least favorably received: (1) medical benefits; (2) funeral expenses; (3) travel lodging expenses; (4) charitable contributions; and (5) direct payment)).

48. Between seventy-one percent and seventy-six percent of respondents reported that benefits would have neither a positive nor negative effect, depending on the benefit. *Id.* at 3001.

49. *Id.* at 3001-02.

50. See *supra* notes 32-40 and accompanying text.

less comfortable with direct cash compensation.⁵¹ Still, even in the least favored category, direct payment, more respondents indicated an increased willingness to donate in light of financial incentives than indicated the opposite reaction.⁵² The study evidenced no indication that financial incentives were likely to result in a net loss in the supply of kidneys.

The Bryce study measured the response to five types of posthumous benefits, ordered here from those which reported the largest net improvement in respondents' attitudes toward donation to those that provided the smallest net improvement: medical expenses, funeral benefits, travel/lodging expenses, charitable contributions, and direct payment.⁵³

One noteworthy finding from the Bryce study is that respondents reported that others were much more likely to be affected by financial benefits than they themselves were.⁵⁴ While the study is not conclusive on this point, it would not be surprising if respondents underreported the influence of financial benefits on themselves out of a desire to appear altruistic, or a general discomfort with admitting to the effect of financial benefits on their willingness to donate. If that were the case, then the higher estimated influence of financial benefits on others is more in line with actual effects we might see under an incentive system.

A study by J.D. Jasper⁵⁵ reported that while a small number of registered donors indicated they would not donate under specific incentive systems, the number of non-donors indicating they would donate if offered an incentive

51. Those indicating that the benefit would have an effect more frequently indicated an increased willingness to donate, measured by the percentage more willing to donate less the percentage less willing to donate. Medical benefits reported the largest net increase, (twenty-three percent), while even direct payment showed a net increase (nine percent) in the percentage of respondents more willing to donate over the percentage of respondents less willing to donate. Bryce et al., *supra* note 47, at 3002. A subset of the respondents identified themselves as registered organ donors, and they also reported an increase in their willingness to donate if incentives were introduced, although the direct cash incentive was less popular with registered donors to a degree that was statistically significant (fifty percent of registered donors registered support for the cash incentive, compared to fifty-six percent of non-donors ($p = 0.004$)). *Id.*

52. Fifty-three percent in favor of direct payment vs. forty-two percent opposed. *Id.* at 3002 tbl.2 ("Respondents' reaction to donor benefits").

53. *Id.*

54. *Id.* For example, while seventeen percent of respondents indicated they were more likely to donate their own deceased family member's organs when asked if direct payment were offered, and sixteen percent reported they were more likely to sign a donor card, fifty-nine percent indicated that they thought it more likely that others would choose to donate if direct payment were offered. *Id.*

55. Jasper et al., *supra* note 32, at 2182 (surveying respondents' attitudes regarding the moral appropriateness of nine different incentives on a 7-point Likert "scale ranging from 1, 'completely inappropriate,' to 7, 'completely appropriate,' with 4 being 'neutral,' and [also] to decide whether they would donate under each incentive policy if it were implemented.").

was significantly higher than the number of donors indicating the converse.⁵⁶ Registered donors favored the altruistic status quo, and a policy of donor recognition, while non-donors gave higher ratings to a cash payment and a lifetime of free driver's licenses and car tags.⁵⁷

A focus group study directed by Thomas Peters reported a marked skepticism from nondonors regarding the organ allocation system, reflected in statements like "'a wealthy person will get the kidney'; 'it won't be done equitably'; 'you'll be passed over'; or 'you're a minority.'"⁵⁸

One final study by Raymond and Patricia Horton compares the attitudes of the general public regarding incentives for organ donation to those of blood donors, finding that respondents who donated blood responded less favorably both to a generic compensation program and to priority on the organ waitlist.⁵⁹ There is reason to think that the opinions of blood donors might better reflect the opinions of the population most likely to donate an organ, because at least one study has found a correlation between a willingness to donate blood and a willingness to register as a kidney donor.⁶⁰

The review of the attitudinal studies suggests two general conclusions. First, the only way to get a clear picture of whether and how financial

56. The smallest net increase in percentage of the respondent population indicating a change in donation plans was reported for the health insurance rebate, with twenty percent of donors indicating they would not donate, and forty percent of non-donors indicating they would donate, while the strongest net gain was reported in funeral expenses, with six percent of donors discouraged and forty-nine percent of non-donors encouraged. *Id.* at 2183 tbl.4 ("Percentages of Donors and Nondonors Indicating Whether They Would Donate Under Each Incentive Policy"). Jasper et al. reported that "[i]f the difference between the two percentages is used to define effectiveness, then the most effective incentives would be [a] payment toward funeral expenses, donor recognition, and preferred status; the least effective would be [a] rebate on health insurance and [a] federal income tax credit." *Id.* at 2183.

57. *Id.* at 2182-83.

58. Peters et al., *supra* note 32, at 2421. A focus group was interviewed consisting of fifty-one registered donors and fifty-one nondonors. *Id.* at 2420.

59. Horton & Horton, *supra* note 31, at 177-78. In a study of 465 adults in an unspecified "local community," 25.4% of respondents answer yes when asked "Do you think the family of a person who becomes an organ donor should receive any form of compensation?", while 41.6% of respondents indicated a willingness to give organ donor card holders "preference in obtaining an organ for an organ transplant operation." *Id.* at 177. In contrast, respondents who had recently donated blood (n=217) reported lower favorability towards both types of incentives. Only "16.5% endorsed any form of compensation," while 20.9% favored preferential placement of donors on the waitlist. *Id.* at 177-78.

60. Philip K. T. Li et al., *Attitudes About Organ and Tissue Donation Among the General Public and Blood Donors in Hong Kong*, 11 *PROGRESS IN TRANSPLANTATION* 98, 99 & tbl.2 (2001) (reporting that only twenty-two percent of randomly selected Hong Kong residents had signed organ donor cards, while forty-nine percent of blood donors had done so).

incentives would change the rate of kidney donation would be to conduct a pilot study.⁶¹ Second, that pilot study needs to be structured as a like-kind exchange or a non-direct benefit, instead of cash-for-kidney exchange, lest it run the risk of providing negligible results, or even discouraging altruistic donation. As this article argues in Part III, *infra*, the public may perceive the proposed scholarship program as operating within the rhetoric of altruism, a suitable reciprocal gift provided in return for the donor-scholar's "gift of life" to the recipient.

C. Scholarship Incentives Would Improve the Logistics of Kidney Allocation

Logistical factors have a measurable impact on the procurement of kidneys for transplantation. While the proposed scholarship incentive that encourages living donation will not necessarily solve every logistical problem, it can mitigate the importance of two factors identified by Kieran Healy as critical inputs to the success of deceased donation: population density and the density of referring hospitals within the area of an Organ Procurement Organization (OPO).⁶²

One challenge facing the current allocation system is that in many areas there are geographical constraints on the efficient allocation of kidneys. In areas where OPOs service large geographical areas, it is often infeasible for kidneys to be recovered from potential deceased donors or to get those kidneys to a recipient in need. For example, LifeCenter Northwest Donor Network is an OPO that covers nearly all of Washington, Idaho, Montana and Alaska.⁶³ Another factor that impacts the success of procurement of cadaveric kidneys is the availability of referring hospitals to communicate with OPOs in a short timeframe.⁶⁴ While deceased donation requires a perfect convergence of circumstances, getting a serviceable kidney from a living donor is not a matter left to chance. Because living donation does not require a fatal injury to the donor, it is less subject to random chance and fortuitous circumstances (such as the manner of the donor's death).⁶⁵ Living donation also relies on fewer intermediaries, and there are thus fewer

61. See, e.g., Bryce et al., *supra* note 47, at 2999 (describing how the empirical question of the impact of incentives on donation rates has been examined by various surveys, but how results have been inconsistent due to different methodologies and differing levels of specificity among the previous studies).

62. KIERAN HEALY, *LAST BEST GIFTS: ALTRUISM AND THE MARKET FOR HUMAN BLOOD AND ORGANS* 61-65 (2006).

63. *Id.* at 61.

64. *Id.* at 65. "A 5 percentage point increase in the density of refer[ring hospitals] raises the procurement rate by about a three-quarters of a point." *Id.*

65. Indeed, the increased usage of safety features like motorcycle helmets and seatbelts reduces the supply of organs through deceased donation. Lance Morrow, *When One Body Can Save Another*, *TIME*, June 17, 1991, at 56.

agents who can “drop the ball” in the process of getting a kidney from its procurement site to the recipient. Indeed, with a living donor, the procurement site is the reception site—donor and recipient will undergo their respective procedures in the same facility. Finally, living donation is a superior alternative to deceased donation, with superior patient and graft survival, and reduced morbidity as expected outcomes.⁶⁶

One final advantage of a scholarship incentive for living donation is that it would prevent the family of the donor from exercising veto power over the donor’s decision. Advocates for deceased donation note that many viable organs are lost when the donor’s family is unwilling to follow through with the donor’s prior decision to donate his or her organs.⁶⁷ When a living donor makes an informed decision to donate his or her organs, that choice is much more likely to be honored.

D. The Scholarship Incentive Can Reduce the Incidence of Unhealthy Kidneys in the Procurement Chain

A scholarship incentive that brings more living donations is likely to reduce the frequency with which recipients receive diseased kidneys. The use of living donors reduces time pressures associated with procurement,⁶⁸ and is likely to improve the amount and reliability of information about a donor’s health.

A lack of information about the donor can have fatal results. For example, recently in Chicago, a deceased donor contracted the AIDS virus and hepatitis C shortly before death. Initial tests did not reveal the recently-acquired infections. As a result, the donor’s organs infected four transplant recipients.⁶⁹ The donor in question had admitted engaging in unspecified high-risk behaviors, and it is unclear whether the recipients were informed of the donor’s risky behaviors. The current shortage of kidneys increases the risks created by limited information—while a recipient can choose to turn down an organ, there is no guarantee that another organ will become available.⁷⁰ The compressed time frame of deceased donation exacerbates the problem—scientists are currently trying to extend the viability of kidneys

66. Jerry McCauley et al., *General Medical Evaluation of the Living Donor*, in *LIVING DONOR TRANSPLANTATION* 27, 27-28 (Henkie P. Tan et al. eds., 2007).

67. See Steve P. Calandrillo, *Cash for Kidneys? Utilizing Incentives to End America's Organ Shortage*, 13 *GEO. MASON L. REV.* 69, 83 & n.60 (2004).

68. See *infra* notes 70-72.

69. Lindsey Tanner, *Organ Donor Infects Four Patients with HIV*, *DAILY HERALD* (Provo, Utah), Nov. 14, 2007, at www.heraldextra.com/content/view/243352/3 (last visited Apr. 9, 2009).

70. *Id.* (reporting that while patients could reject a kidney because of concerns raised by a doctor, “the availability of organs is such that if you pass, there’s a possibility you won’t get one.”).

stored outside the body from three to six days,⁷¹ but the time within which a kidney must be placed in a solution to keep it viable can be as short as forty minutes.⁷² Had the Chicago donor been a living donor, the time pressure would have been less severe, and there likely would have been adequate time to run secondary tests on the donor. While living donors can lie about their health risks, and some might, mandatory tests for infections like HIV and hepatitis can and should be part of the scholarship incentive program.

Some have argued that live donation by compensated donors will increase incidence of diseased organs entering the procurement chain.⁷³ Richard Titmuss, in his seminal book *The Gift Relationship*, argued that markets in blood would not only drive out altruistic behavior, but would also contaminate the blood stream, because the poor, diseased, and drug ridden would be the only ones desperate enough to need the money, and thus the only parties willing to provide blood.⁷⁴ Titmuss reached this conclusion by comparing the United States blood market of the late 1960s and early 1970s with the nonmarket donation system in the United Kingdom. Titmuss' book was so influential that the U.S. abandoned markets for blood in the mid-seventies, embracing an entirely altruistic system.⁷⁵ What Titmuss did not predict was that the exclusively altruistic system exacerbated the problem of HIV-infected blood in the nation's supply, because the altruistic system made the blood banks feel beholden to its donor population and unwilling to risk alienating them, even when evidence indicated that accepting donations from some donor groups presented an increased risk of contaminating the blood supply.

When it first became evident in the early 1980's that AIDS, a then-unidentified contaminant, had started manifesting itself in the donated blood supply, both blood and plasma procurement industries made missteps that led to infections of those receiving blood transfusions. Blood banks, which only accepted altruistic donations and thus were dependent on volunteers,

71. Michael Arndt, *A Longer Shelf Life for Transplant Organs*, BUS. WK., Oct. 21, 2002, at www.businessweek.com/magazine/content/02_42/c3804107.htm (last visited Apr. 9, 2009).

72. See N.R. Brook & M.L. Nicholson, *Kidney Transplantation from Non Heart-Beating Donors*, 1 SURGEON: J. ROYAL C. SURGEONS EDINBURGH & IRELAND 311, 311 (2003) (noting that kidneys only remain viable for approximately forty minutes after cardiac arrest).

73. As one blogger speculated about kidney sales in the Philippines, "those who typically sell their kidneys aren't the type of person who'd care that much about maintaining their health, nor do they have the ability to do so." *Organ Trade in the Philippines: Signs of the Times?*, <http://health.tesstermulo.com/?p=376> (Oct. 4, 2007, 11:03 pm) (last visited Jan. 16, 2009).

74. See RICHARD M. TITMUSS, *THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY* 75-76 (Vintage Books 1972) (1971) (positing that the treatment of blood as a market good leads drug addicts, alcoholics, and carriers of diseases to donate).

75. HEALY, *supra* note 62, at 89.

were afraid of alienating homosexual populations—which as a group donated blood well above the national average—realizing that doing so was likely to result in a shortage of available blood. Thus, the blood banks did not start screening donors, instead interpreting as inconclusive data that suggested that homosexual populations were at higher risk of contracting and communicating AIDS.⁷⁶ Conversely, plasma banks, which paid for their product, did not feel beholden to donor groups and screened donors once the AIDS issue came to light, but miscalculated the risk of leaving older supplies of plasma on the market.⁷⁷

Unlike blood supply, kidney donation occurs on a smaller scale, and each living donor can be tested for infections that put the recipient at risk. Some may be concerned about a testing program violating the privacy of individual donors.⁷⁸ However, the scholarship incentive program can be structured so that information revealed during testing is kept private from those parties not directly involved with the procurement or transplantation processes. While there may be populations that are less likely to qualify for a kidney scholarship, that determination will not need to be made based on stereotyping or questions about certain risk-increasing behaviors that are also associated with certain lifestyle choices. Instead, careful tests can verify when a donor's kidney will present a risk to a recipient and therefore must be kept out of the procurement chain. Finally, there is a statutory requirement to prevent "the acquisition of organs that are infected with the etiologic agent for acquired immune deficiency syndrome."⁷⁹ Carefully testing living donors before donation should assist in meeting that goal. Contrary to the fears of Titmuss and those who have embraced his research, a market in organs will not necessarily lead to widespread contamination, and may actually decrease the incidence of diseased organs in the transplant chain.

E. Unequal Distribution Across Racial Groups

If a scholarship program could effectively reduce the waitlist to zero and provide kidneys for every patient that evidences medical need, then it would successfully deal with one of the major problems in the current organ

76. *Id.* at 98-103.

77. *Id.* at 103-06.

78. See Richard A. Epstein, *The Legal Regulation of Genetic Discrimination: Old Responses to New Technology*, 74 B.U. L. REV. 1, 12-13 (1994) (explaining that some parties take privacy seriously in order to protect themselves from having potential embarrassing information being exposed to society).

79. 42 U.S.C. § 274(b)(2)(E) (2000).

allocation system: disparities in allocation across racial categories.⁸⁰ These disparities are due in part to the method used to match kidneys to recipients⁸¹ and in part to the actual discrimination that creeps into the process of admitting prospective recipients onto the waitlists in the first instance.⁸²

It is not safe to assume, however, that the proposed scholarship program would effectively reduce the waiting list to zero and then maintain a perfect balance between donors and recipients. It is more likely that either the scholarship system procures more kidneys, but not enough to clear out the waiting lists, or that if the incentive is particularly effective, there will be more donors waiting to qualify for the scholarship than there are recipients waiting for kidneys. In either case, the scholarship incentive must deal with the same difficult question: how to correct the racial disparity that exists in the current organ allocation regime?

There are significant risks inherent in upsetting the current allocative apple cart. One of the key findings by Kieran Healy is that the practices of and economic investments by OPOs have a significant impact on the success of providing kidneys for needy recipients.⁸³ Unless the scholarship program can guarantee that living donors will completely supplant deceased donors, any new policy has to protect the efficient aspects of the current procurement system.

Currently, kidney procurement is handled by fifty-nine OPOs⁸⁴ grouped into eleven regions. Some OPOs are net importers of organs, and others are net exporters. Each OPO gets to set allocation rules within its service

80. GOODWIN, *BLACK MARKETS*, *supra* note 2, at 96 (stating that “[w]ith regard to kidney transplantation, the waiting time for Black Americans is 74% longer than for Whites.”).

81. Michele Goodwin, *Altruism’s Limits: Law, Capacity, and Organ Commodification*, 56 RUTGERS L. REV. 305, 353-56 (2004) [hereinafter Goodwin, *Altruism’s Limits*]. The end result of UNOS’s method of matching antigens in patients has a net effect of leaving Blacks on the waitlist for a longer period of time. See *id.* at 354. This is in part because matching antigens are rarer among Blacks than Whites, and partly because Blacks have a higher rate of sensitivity to donor antigens regardless of donor race. *Id.*

82. GOODWIN, *BLACK MARKETS*, *supra* note 2, at 90-96 (discussing evidence of “green screening” and racial stereotyping that prevents some prospective recipients from being added to waitlists in the first instance).

83. HEALY, *supra* note 62, at 66-67. According to Healy, “[d]onation . . . is also strongly affected by the resources and scope of the procurement agency. . . . [T]he individual capacity for altruism and the social organization of procurement are not separate questions but rather two aspects of the same process. . . . [O]rganizations create ‘contexts for giving’ [and] . . . help create their own donor pool.” *Id.*

84. Nat’l Kidney Found., 25 Facts About Organ Donation and Transplantation, at www.kidney.org/news/newsroom/fs_new/25factsorgdon&trans.cfm (last visited Apr. 9, 2009).

area.⁸⁵ While the Department of Health and Human Services has tried to shift to a national allocation system, organs are primarily shared within regional boundaries, in part due to the time pressures imposed by relying predominantly on deceased donation.⁸⁶ Kidneys are not allocated based on who was first-in-time on the waiting list, but generally to the recipient whose blood antigens best match those of the donor.⁸⁷ Matching is based on six specific human leukocyte antigens (HLAs), and where a donor and a prospective recipient are a perfect match, an OPO is bound by rules crafted by UNOS to provide the kidney to that recipient.⁸⁸ Otherwise, the OPO decides how to allocate kidneys within its area.

Given the importance of maintaining an infrastructure to process donated organs, at first glance it seems reasonable to match scholarships with OPOs. For example, if OPO #1 has 1,200 prospective recipients waiting for kidneys, then 1,200 scholarships would be provided through OPO #1. OPO #1 would conduct tests and make sure each donated organ is a healthy match for a recipient from its area. If there were no matches in the area, the OPO could then match the organ with a recipient in its region or perhaps nationwide. In theory, tying the benefits of kidney donation to the need in the community could be the most efficient way of dealing with concerns about uneven distribution of kidneys. However, given the racial inequities in the current procurement system, there is good reason to think that administering the scholarship program through OPOs in the same way that they have managed non-market donations will lead to shorter lists, but with the same allocative inequities. Blacks may wait a shorter time because of the increased number of kidneys available, but they will still wait twice as long as White recipients.⁸⁹

A second option which would capitalize on pre-existing administrative capacity would be to manage scholarships by state, and let the state legislatures handle the allocative details. As of May 1, 2009, 1,274 potential recipients are waiting for kidneys in the state of Washington.⁹⁰

85. Jeffrey Prottas, *The Politics of Transplantation*, in *ORGAN AND TISSUE DONATION: ETHICAL, LEGAL, AND POLICY ISSUES* 9 (Bethany Spielman ed., 1996).

86. The time available to get a kidney into a solution necessary to keep it viable can be as short as forty minutes. Brook & Nicholson, *supra* note 72, at 311.

87. See, e.g., Ian Ayres et al., *Unequal Racial Access to Kidney Transplantation*, 46 VAND. L. REV. 805, 819-20 (1993) (explaining how recipients receive kidneys according to the quality of the antigen match).

88. Prottas, *supra* note 85, at 13.

89. GOODWIN, BLACK MARKETS, *supra* note 2, at 45 (reporting that in 2003, Blacks waited an average of 1,891 days compared to 840 days for Whites).

90. THE ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, CURRENT U.S. WAITING LIST OVERALL BY ORGAN, at www.optn.org/latestData/step2.asp? (select "Waiting List" then "Organ by State") (last visited May 11, 2009).

Donors could be matched to recipients by geographical proximity to one of the state's five transplant centers, and scholarships for donors could fund studies at state-run colleges and universities. Because state legislatures are elected bodies, it is possible that they would be more sensitive to concerns about racial equality, and that they might put some pressure on the inequities created by the current system of allocation.

Another option might be to match donors and recipients by race: if 30,000 Blacks are waiting for kidneys, then 30,000 kidney scholarships should be made available to Blacks.⁹¹ This might address the racism in current distribution methods. This solution, however, might also run afoul of recent Supreme Court decisions arguing for race neutral application processes for high schools and undergraduate institutions.⁹² The Court has taken the stance that the only way to prevent discrimination based on race is to stop discriminating based on race.⁹³ Thus, a program that preferences Black applicants over other applicants could be found to be a violation of the Fourteenth Amendment.

One method of avoiding that problem would be by providing scholarships only for graduate level and professional programs, for example law and medical degrees. The Supreme Court held that while it was unconstitutional to use race-based factors to select applicants for an undergraduate program,⁹⁴ it was constitutional to use race-based factors to select entrants in a professional program because maintaining a diverse student body had an inherent educative value and was "essential to its educational mission."⁹⁵ However, there may not be enough supply of donors who are qualified to go into law, business, and medicine sufficient to meet the need for donated kidneys.⁹⁶

91. This would address the current disparity of need—the neediest population for organs could be served by the (arguably) neediest population in terms of education. Goodwin, *Altruism's Limits*, *supra* note 81, at 357; see also NICOLE STOOPS, U.S. CENSUS BUREAU, EDUCATIONAL ATTAINMENT IN THE UNITED STATES: 2003, at 3 tbl.A (2004), available at www.census.gov/prod/2004pubs/p20-550.pdf (last visited Apr. 9, 2009) (noting that Blacks have a lower percentage than other racial groups of individuals who receive a bachelor's degree or more).

92. *Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701 (2007) (barring race-based regimes for allocating students to high schools); *Gratz v. Bollinger*, 539 U.S. 244, 270 (2003) (finding that a program which favored "underrepresented minority" applicants solely because of race was not narrowly tailored to achieve an interest in educational diversity).

93. *Seattle Sch.*, 555 U.S. 701.

94. *Gratz*, 539 U.S. at 270, 275.

95. *Gutter v. Bollinger*, 539 U.S. 306, 329, 343 (2003).

96. A recent article notes that law school applicants dropped to 83,500 from 98,700 in 2006, and medical school applicants from 46,080 in 1997 to 42,000. Alex Williams, *The Falling-Down Professions*, N.Y. TIMES, Jan. 6, 2008, at www.nytimes.com/2008/01/

Perhaps the scholarship incentive program would be best served by facing the constitutional question head on. A suit over unconstitutional scholarship distribution could bring concerns about racial inequities in kidney allocation to the fore, and perhaps lead to changes in the legal structure for kidney markets. Indeed, if the race-based admission process for the proposed scholarship program is invalidated as a violation of the Equal Protection clause, a racially-discriminatory admission process for kidney waitlists should also be held to violate the Equal Protection clause.⁹⁷

There are two further risks associated with lining up donors and recipients along racial lines. First, not every donor or recipient will automatically self-identify as a member of a particular ethnicity. Individuals should not be shoehorned into one racial group or another to qualify for consideration under the scholarship program. In addition, as discussed in Part II.B, *supra*, some evidence indicates that Blacks are less likely to donate, and systems of commodification are less likely to make a positive net impact in their willingness to donate. If Blacks continue to be underrepresented in donor populations but overrepresented on waitlists, then a system matching donor to recipients by race will still result in Black recipients waiting a disproportionate amount of time to receive a kidney.

One common theme in accounts of lower donation rates among Blacks is the notion that they distrust the current allocation system.⁹⁸ Blacks are more likely to express the belief that persons of color will not get access to donated kidneys, and thus, that their donations are less likely to have a

06/fashion/06professions.html?_r=1&scp=1&sq=the%20falling%20down%20professions&st=cse (last visited Apr. 9, 2009). For example, in the 2005-2006 academic year, the 195 ABA certified law schools granted only 43,883 juris doctorate degrees. American Bar Association, JD. and LL.B Degrees Awarded, *available at* www.abanet.org/legaled/statistics/charts/stats%20-%207.pdf (last visited Apr. 9, 2009).

97. "Although all governmental uses of race are subject to strict scrutiny, not all are invalidated by it. As we have explained, 'whenever the government treats any person unequally because of his or her race, that person has suffered an injury that falls squarely within the language and spirit of the Constitution's guarantee of equal protection.'" *Grutter*, 539 U.S. at 326-27 (quoting *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 229-30 (1995)).

98. See GOODWIN, BLACK MARKETS, *supra* note 2, at 49 (reporting the findings of a study conducted among African Americans in 2003 which reported high levels of distrust regarding organ donation); see also HEALY, *supra* note 62, at 61 (summarizing research that reports high levels of distrust for the donation process among Blacks, and that OPOs with higher concentrations of Blacks within their boundaries have measurably lower levels of procurement); see also Laura A. Siminoff & Christina M. Saunders Sturm, *African-American Reluctance to Donate: Beliefs and Attitudes About Organ Donation and Implications for Policy*, 10 KENNEDY INST. ETHICS J. 59, 63 tbl.1 (2000) (reporting that 40.0% of African-American respondents agree that "[t]he way it's decided who gets an organ is unfair", compared with 30.7% of White respondents who agreed).

positive impact in their own communities. Surveys comparing Black and White respondents report that Black respondents are more likely to believe that if a doctor knows a patient is an organ donor, the doctor will not do as much to save the patient's life.⁹⁹ A scholarship system designed to recruit Black donors with credible assurances of fair allocation could potentially alter expectations about the procurement system and create a shift in donating patterns, thus ameliorating some of the concerns noted above.¹⁰⁰

The next three Parts of this article identify three specific obstacles to the scholarship proposal, and argue that in each case the scholarship incentive fills the gap between the poles of unfettered commodification and exclusive altruism. Part III responds to concerns about the rhetorical importance of altruistic language and meaning in the kidney procurement regime. Part IV identifies the potential coercive and exploitive dangers presented by systems of commodification, and explains through appeals to heuristics and brain morphology how the proposed scholarship incentive reduces coercive and exploitive pressures. Part V identifies the current statutory obstacles to any incentive system and suggests innovative ways to work within the meaning of the statute to create room for pilot programs like the proposed scholarship incentive.

III. SCHOLARSHIP INCENTIVES PRESERVE THE LANGUAGE AND RHETORIC OF ALTRUISM

In order to rise to Professor Goodwin's challenge to determine the appropriate level of commodification,¹⁰¹ it is necessary to deal with the competing rhetoric of exclusive altruism versus unrestricted commodification and look for possible common ground between the two.¹⁰² As the anthropologist Donald Joralemon explains, both poles of the debate operate like the rhetorical equivalent of the anti-rejection drugs.¹⁰³ Briefly, in order to keep the transplant recipient's body from rejecting a new organ, the recipient must take certain drugs that limit immune responses.

99. *Id.* (reporting that 37.9% of African-American respondents and 21.2% of White respondents agree with the following statement: "I worry that if the doctors know that I am an organ donor, they won't do as much to save my life.").

100. Nevin Gewertz & Michele Goodwin, *Rethinking Colorblind State Action: A Thought Experiment on Racial Preferences* (manuscript at 28, on file with the author).
es (manuscript at 28, on file with the author).

101. Goodwin, *Private Ordering*, *supra* note 6, at 1369, 1384.

102. See, e.g., Peter Singer, *Freedoms and Utilities in the Distribution of Health Care*, in *MARKETS AND MORALS* 149, 163-64 (Gerald Dworkin et al. eds., 1977) (discussing both the positive and negative outcomes of commodification and altruism in the blood donation industry).

103. See Donald Joralemon, *Organ Wars: The Battle for Body Parts*, 9 *MED. ANTHROPOLOGY Q.* 335, 348 (1995).

Rhetorical structures are designed to make palatable, then acceptable, finally noble, the somewhat frightening reality of removing an organ from one human being's body and placing it within the body of another. Medical professionals have overwhelmingly chosen to present the procurement of kidneys for transplantation and its attendant medical realities as a gift, appealing to the rhetoric of altruism to suppress a potentially negative social reaction. The language of the National Organ Transplantation Act (NOTA) and the Uniform Anatomical Gift Act (UAGA)—and their criminal sanctions—strengthen that commitment to altruistic rhetoric.¹⁰⁴ As a practical matter, it is dangerous to even suggest stepping outside of the altruistic regime in the process of arranging a kidney transplant.¹⁰⁵ Likewise, the choice of some advocates of incentive programs to couch their arguments in terms of autonomy instead of market forces or efficiency¹⁰⁶ appears to be a conscious choice to shape the debate in a fashion that makes their position more acceptable to those who might mistrust markets,

104. National Organ Transplant Act (NOTA), 42 U.S.C. § 274e(b) (2000) (stating “[a]ny person who violates [NOTA] . . . shall be fined not more than \$50,000 or imprisoned not more than five years, or both.”); REV. UNIF. ANATOMICAL GIFT ACT § 16(a) (revised 2006) (stating “a person that for valuable consideration knowingly purchases or sells a part for transplantation or therapy . . . is subject to a fine . . . or imprisonment”); see Michael H. Shapiro, *Regulation as Language: Communicating Values by Altering the Contingencies of Choice*, 55 U. PITT. L. REV. 681, 687 (1994) (arguing that if regulatory systems reinforce or attenuate “certain preferences, attitudes, beliefs and dispositions,” then it is crucial to recognize that regulation communicates “basic societal ideas.”); see generally JAMES BOYD WHITE, *HERACLES’ BOW: ESSAYS ON THE RHETORIC AND POETICS OF THE LAW* 203 (1985) (discussing how criminal law creates a system of rhetoric of meaning which defines the roles and starting points of the various actors in the system); JAMES BOYD WHITE, *WHEN WORDS LOSE THEIR MEANING: CONSTITUTIONS AND RECONSTITUTIONS OF LANGUAGE, CHARACTER, AND COMMUNITY* 245 (1984) (arguing that treaties and constitutions set a baseline for the conversations that we can have about the law and the roles of the various actors within it, “alter[ing] the rhetorical conditions of life for those in whose name they are promulgated and those to whom they speak.”).

105. One can witness this effect at matchingdonors.com, a website that provides a forum for needy potential recipients to solicit willing altruist donors. The website warns, “[i]t is absolutely against the law to have any financial benefit from organ donation. If you are paid, or request to be paid, for any transplant you will be prosecuted to the full extent of the law. Violators of this criminal prohibition, can be subject to \$50,000 fines and/or five years of imprisonment [sic]. Our terms allow us to give all of your personal, contact and tracking information to the FBI without your permission if you violate this prohibition.” MatchingDonors.com, Potential Organ Donor Login, at www.matchingdonors.com/life/Donor/index.cfm?page=login&requested=desktop.cfm?&string=page=main (last visited Apr. 9, 2009).

106. See, e.g., Sally L. Satel & Benjamin E. Hippen, *When Altruism Is Not Enough: The Worsening Organ Shortage and What It Means for the Elderly*, 15 ELDER L.J. 153, 198 (2007) (“Paradoxically, the current system based on altruism-or-else undermines the respect for individual autonomy that is at the heart of the most widely held values in bioethics.”).

but embrace concepts of human dignity and liberty. Joralemon, however, postulates that successfully “suppressing the cultural rejection” of transplantation might require “some combination of supporting ideologies, some blend of gift and market rhetoric and policy.”¹⁰⁷ His intuition is echoed by modern scholars.¹⁰⁸ The proposed scholarship incentive possesses just such a potential to preserve a rhetorical middle ground between the current regime of unrewarded gifting and the oft-advocated corrective of unrestrained commodification.

Historically, the debate over kidney shortages has taken place at the poles. Some of the opposition to commodification-oriented solutions stems from a desire to protect exclusively altruistic donation because it is understood to perform important rhetorical functions. Indeed, altruism purists raise several salient concerns about commodification. First and foremost, altruism purists are concerned that altruism is too fragile to withstand the encroachment of a market for kidneys.¹⁰⁹ Thus, the argument goes, any commodification runs the risk of triggering a net loss of kidneys available for transplantation, because donors responding to altruistic urges will be disgusted by and turn away from donation once market forces take hold. In addition, altruism purists argue that the sale of organs sends the wrong message about the sanctity of human life and human bodies.¹¹⁰

107. Joralemon, *supra* note 103, at 348. Ethicist Suzanne Holland recognizes that “how we think of things, the conceptual framework that we use, in large measure shapes what we do with those things.” Suzanne Holland, *Contested Commodities at Both Ends of Life: Buying and Selling Gametes, Embryos, and Body Tissues*, 11 KENNEDY INST. ETHICS J. 263, 273 (2001). But Holland views the conceptual framework as fundamentally dichotomous. She argues that “[i]f we think of the body as a fungible entity, we are more likely to be comfortable with a market that exchanges it for other fungible entities—e.g., body tissues traded off for collagen treatments. If, on the other hand, we think of the body as inalienable, we will not want to subject it to the vicissitudes of the market.” *Id.* at 274.

108. See, e.g., Martha M. Ertman, *What’s Wrong with a Parenthood Market? A New and Improved Theory of Commodification*, 82 N.C. L. REV. 1, 51-52 (2003) (endeavoring to find a middle ground between what sociologist Viviana Zelizer calls Radin’s “Hostile Worlds” view of commodification with Posner’s “Nothing But” advocacy of commodification to advocate for partially commodified family structures where commodification creates “Differentiated Ties,” improving connections and increasing affection through commodification, not in spite of it) (citing Viviana A. Zelizer, *The Purchase of Intimacy*, 25 LAW & SOC. INQUIRY 817, 818-19, 826 (2000)).

109. See Singer, *supra* note 102, at 163-64. Singer argues that what is threatened by the commodification of goods like blood—and by analogy, kidneys—is “the right to give something that cannot be bought, that has no cash value, and must be given freely if it is to be obtained at all. This right . . . really is incompatible with the freedom to sell, and we cannot avoid denying one of these freedoms when we grant the other.” *Id.*

110. See Carson Holloway, *Monetary Incentives for Organ Donation: Practical and Ethical Concerns*, in ORGAN AND TISSUE DONATION: ETHICAL, LEGAL, AND POLICY ISSUES 152 (Bethany

They also assert that even if the commodification of body parts itself did not destroy altruistic giving, it would provide the grounds for a rapid slide down a slippery slope. There is a fear that ceding any ground to market forces cedes the battle en toto. Soon, other forms of bodily commodification—e.g., slavery, baby selling, or doctor assisted suicide with an associated sale of salvageable organs—would become the norm, and altruistic systems would become the outlier, more difficult to conceptualize or implement.¹¹¹

Some will argue that the scholarship incentive program is flawed from the outset. Critics will undoubtedly find something morally repugnant about the suggestion that those who might not otherwise be able to afford college should be required to give up a kidney to access educational opportunities. I cannot disagree with the core sentiment expressed in that concern. The scholarship incentive would certainly be undesirable in an ideal world where everyone who desired might obtain a college degree, regardless of financial limitations. Unfortunately, this is not the world in which we live. As Margaret Radin recognized, there is value in striving toward ideal justice, which in the ideal world will “avoid all significant harms to personhood and community”.¹¹² However, in *this* world, conditions are not ideal, and we are often forced to select the best alternative of those available, instead of the ideal.¹¹³ There would be no reason to propose the scholarship incentive to address the shortage of kidneys if the populace was sufficiently motivated to engage in unrewarded giving.¹¹⁴ There would also be no reason to worry that a system of commodification would exploit the poor if there were not people whose circumstances made the inconvenience and risk of donating a kidney well worth the compensation they would receive in a hypothetical unrestricted market. But the proposed scholarship incentive is conceived

Spielman ed., 1996) (explaining the belief that commodification of the human body degrades the human person).

111. Margaret Radin describes this as the “domino theory” of commodification, which assumes that “anytime we find market and nonmarket understandings coexisting, . . . it is inevitable that the market understanding will win out.” MARGARET JANE RADIN, *CONTESTED COMMODITIES* 103 (1996). Thus, for subscribers to the domino theory, to entertain any notion of commodification is to admit defeat and to allow the barbaric rhetoric of the market to storm the gates. Radin finds the “domino theory” too simplistic, stating that “it concedes too much to commodification to argue that certain specific items (for example, blood) must remain completely noncommodified so as to keep open opportunities for altruism[.]” *Id.* at 107. She argues instead that “[t]he way to a less commodified society is to see and foster the nonmarket aspect of much of what we buy and sell, to honor our internally plural understandings, rather than to erect a wall to keep a certain few things completely off the market and abandon everything else to market rationality.” *Id.*

112. *Id.* at 123.

113. *Id.*

114. See generally *supra* Part II.A.

with an eye toward “society as it is.”¹¹⁵ This article presupposes that it is not “responsible to allow some to die on the outside chance that someone will be touched by the spirit of generosity . . . merely to preserve one of many possible avenues for the expression of [that] generosity.”¹¹⁶ Turning exclusively to altruism to remedy the shortfall in transplantable organs cannot be justified on the basis of its effectiveness, because it falls far short of current and projected need. However, altruism purists have suggested that such exclusivity is rhetorically necessary to preserve organ donation.

This Part responds to these concerns by arguing that the proposed scholarship incentive fits within the rhetorical sphere of altruistic giving, having the potential to preserve the rhetoric of altruism while simultaneously providing incentives to increase donation.¹¹⁷ The scholarship incentive aspires to secure a sufficient number of organs in a fashion that is not hostile to ethical traditions, and which protects individuals from coercion and exploitation better than a system of outright commodification would. The scholarship incentive is envisioned as a means of maintaining the rhetoric of altruism, and protecting the concept of donation as reciprocal gifting, where donor and recipient both receive and give. The donor gives of herself physically, and the recipient gets a likely increase of both the duration and quality of life. The recipient, mostly through the mechanisms of insurance (private or government) gives the donor an educational benefit that provides a likely increase to the donor’s quality of life, and perhaps life expectancy as well.¹¹⁸ In important ways, the kidney donor as scholarship

115. Arthur J. Matas et al., *A Proposal for Cadaver Organ Procurement: Routine Removal with Right of Informed Refusal*, 10 J. HEALTH POL. POL’Y & L. 231, 242 (1985).

116. *Id.*

117. *But see* Evans, *supra* note 33, at 1019-20, 1022 (reporting on a pilot study regarding incentives for deceased organ donation where respondents balanced a \$25,000 voucher for hospital costs against the mounting debt a hypothetical family faced to keep a family member on life support, but did not balance a \$25,000 cash incentive or a \$2,000 voucher for funeral expenses against the mounting debt). Evans concluded that “a medical bill voucher is considered to be in the same sphere as the medical bill, and these two variables can therefore be commensurated. However, equating the surgical removal of organs with an object outside of the medical sphere—such as the college education the family could buy with the \$25,000 hypothetical payment—violates our sense of the sacredness of these institutional boundaries. Pure commodification of organs—with fungibility outside of the medical sphere—is therefore not engaged in by the respondents. The more limited commodification from medical vouchers, where they are used as money internal to the medical sphere, is.” *Id.* at 1022 (internal citation omitted).

118. One Japanese study found a measurable correlation between educational attainment and life expectancy. Yoshihisa Fujino et al., *A Nationwide Cohort Study of Educational Background and Major Causes of Death Among the Elderly Population in Japan*, 40 PREVENTIVE MED. 444, 446 (2005).

recipient sustains the rhetoric of gift that is essential to preserving a workable social conception of kidney procurement.

A. *The Rhetoric of the Gift*

Those opposed to increasing organ donation through an open market are also suspicious of restricted regimes of commodification. While proponents of such restricted regimes call them “rewarded gifting”,¹¹⁹ others see rewarded gifting as “a terminological subterfuge meant to [obscure] the real issue” of kidney donation.¹²⁰ The anthropologist Emiko Ohnuki-Tierney suggests that the gift metaphor disguises “a transaction completely devoid of social relationships,” a market wolf draped in the wool of altruism.¹²¹ However, viewing kidney procurement through an exclusively donative lens is also a terminological subterfuge,¹²² recognized even by those who are opposed to market-based solutions.¹²³ Organ donation as gift is entirely illusory rhetoric, inasmuch as it applies to actors in the system other than the donor herself. The sociologist Kieran Healy speaks of the current model of kidney donation as a deliberate attempt to preserve the concept of the gift, even though the reality of kidney donation is that it requires a coordinated allocation market to make sure the donated kidney gets from the donor to

119. See Daar, *supra* note 7, at 182.

120. B.N. Colabawalla, Letter to the Editor, *High Mortality Among Recipients of Bought Living-Unrelated Donor Kidneys*, 336 LANCET 1194 (1990). Holland echoes that sentiment, suggesting that overt commodification would be preferable to the current regime of altruistic donation, where the gift of “[a] donated embryo—or body tissue” generates market profit for those who use and research donated embryos. Holland, *supra* note 107, at 280.

121. Emiko Ohnuki-Tierney, *Brain Death and Organ Transplantation: Cultural Bases of Medical Technology*, 35 CURRENT ANTHROPOLOGY 233, 241 (1994). “[D]onated organs—‘the gift of self,’ literally—are not and cannot be the gift of self because organ donation lacks the most critical element of gift giving and exchange: *social relationship*. . . . Without the social context in which real social agents engage in a transaction, the organ . . . becomes a candidate for commoditization.” *Id.*

122. See Joralemon, *supra* note 103, at 336 (describing the gift rhetoric of organ procurement as analogous to anti-rejection drugs). Joralemon argues that by packaging organ donation into gift rhetoric, we inhibit cultural rejection of transplantation and its views of the body. *Id.* “What I am arguing is that, at least for the present and near future, the *cultural* success of transplantation will be measured by how effectively its supporting ideology suppresses, rather than replaces, traditional concepts of bodily integrity This is the standard by which to judge the likely outcome of the conflict between gift and property rights’ advocates.” *Id.* at 347.

123. Heléna Ragoné, *The Gift of Life: Surrogate Motherhood, Gamete Donation, and Constructions of Altruism*, in TRANSFORMATIVE MOTHERHOOD: ON GIVING AND GETTING IN A CONSUMER CULTURE 65, 65-66 (Linda L. Layne ed., 1999) (suggesting that gift rhetoric has been “lavishly applied” to blood and organ donation in “an attempt by participants and by society to retard, at least symbolically, the trend toward the commodification of life.” (internal citations omitted)).

the recipient.¹²⁴ Recipients of kidneys either pay out of pocket or turn to private or public insurance to purchase kidneys from procurement agencies, which generate income by arranging transplants.¹²⁵ Doctors who perform transplants are never asked to donate their services because of a concern that to do otherwise would corrupt the process. Only the donor is treated as potentially subject to corruption via commodification.¹²⁶

Nevertheless, transplant service providers are so wedded to gift language that they are uncomfortable with donors who evidence anything other than pure altruistic motives. For example, in one highly publicized case, a hospital in Toronto rejected a donor who was, in their estimation, "motivated by [a] desire for publicity . . . not by altruism."¹²⁷ This rejection reflects the current perspective of the transplantation community which accepts living donations from nondirected donors (i.e., donors not related to or solicited by the recipient) only when their motives are "good" and their mental health is "balanced." Nondirected donors who seem overly interested in media coverage are not only viewed to pose a threat to the anonymity and privacy of the donor, but also a risk that their decision to donate might be animated by misguided motives.¹²⁸

124. See HEALY, *supra* note 62, at 70 (explaining how organ donation and blood donation are the best examples of altruistic behavior and both have the symbolic resemblance of an anonymous gift).

125. Mark Katches et al., *Donors Don't Realize They Are Fueling a Lucrative Industry*, ORANGE COUNTY REG., Apr. 16, 2000, at 1, at www.ocregister.com/features/body/day1.shtml (last visited Apr. 9, 2009) ("Companies and tissue banks step around the law by charging marked-up fees to handle and process the body parts. They avoid billing for the tissue itself. The law allows for reasonable fees to cover processing costs without defining reasonable. Tissue banks also avoid using the word 'sales.' But Judy Perkins, executive director of the University of California, San Diego, Regional Tissue Bank, calls fees a euphemism for sales.").

126. Often, however, those who donate organs or gametes do not realize that they are contributing to a system rife with commodification. See, e.g., Holland, *supra* note 107, at 264 ("On hearing of such cases, people often feel 'cheated,' duped, conflicted, and even angry. As one woman said, 'I thought I was donating to a nonprofit. I didn't know I was lining someone's pocket. . . . It makes me angry. It makes me appalled. If it's not illegal, it ought to be. It's certainly immoral.'") (internal citations omitted).

127. Laura Meckler, *For Religious Group, True Charity Begins on Operating Table*, WALL ST. J., Dec. 13, 2007, at A1.

128. See M.A. Dew et al., *Guidelines for the Psychosocial Evaluation of Living Unrelated Kidney Donors in the United States*, 7 AM. J. TRANSPLANTATION 1047, 1049 & tbl.2 (2007) (noting a higher risk for donors whose motives reflect a desire for recognition such as a desire for publicity or a desire for a personal relationship); Patricia L. Adams et al., *The Nondirected Live-Kidney Donor: Ethical Considerations and Practice Guidelines: A National Conference Report*, 74 TRANSPLANTATION 582, 587 (2002) (reporting at a national conference of the transplantation community that a nondirected donor "who seems overly interested in media coverage should not be accepted because of the potential impact of media coverage on the recipient's anonymity and privacy.").

This tension is manifest even in concerns about an OPO's own media communications regarding transplantation.¹²⁹ OPOs are conflicted about using the gift of a nondirected donor for PR purposes, even though one journalist characterized such a PR photo as "a big thing for the hospital, to have a stranger donate his kidney"¹³⁰ For example, Chaya Lipschutz, a self-appointed kidney matchmaker, draws suspicion from hospitals in part because "she does offer the promise that 'if you donate, people will think the world of you, you'll feel gratified, it'll boost your self esteem,' an expectation of quid pro quo which might horrify a professional transplant coordinator. Frankly, some hospitals are wary of Chaya, and won't deal with her."¹³¹

One of the key factors OPOs look for in conducting the psychological screening of nondirected donors is that they have evidenced a commitment to altruism in other areas of their lives.¹³² It is interesting to note that this rhetorical commitment to pure altruism does not fully translate into other areas where products of the body are at least incompletely commodified: sperm, eggs, plasma and surrogate motherhood.

When comparing organ donation with the donation of other body products which are commodified, there is reason to think that the rhetoric of gift as applied to body parts is merely that: rhetoric. Sperm or egg "donors" actually sell the products of their body to "recipients" who purchase them (or who have insurance that purchases them). These "donors" and "recipients" of gametes frequently invest themselves in a rhetorical structure that allows them to emphasize the social benefit of the transfer of gametes while downplaying the financial realities of the transaction.¹³³ As Martha Ertman has articulated, donors and recipients operate within an open market¹³⁴—even the mediator's title of "sperm bank" clearly belies the rhetoric of gift

129. *Id.* "[T]he OPO must be cautious in educational brochures that show photos of the [nondirected donor] and recipient together, implying that such a meeting is commonplace after the transplant." *Id.*

130. *This American Life: #347 Matchmakers*, 30:09 (Chicago Public Radio broadcast Jan. 18, 2008).

131. *Id.* at 26:08.

132. See, e.g., L. Wright et al., *Living Anonymous Liver Donation: Case Report and Ethical Justification*, 7 AM. J. TRANSPLANTATION 1032, 1033-34 (2007) ("The donor had performed various conventional acts of altruism such as blood donation and community service, was on a bone marrow registry and had a signed organ donor card. We viewed these as sufficient evidence that his primary motive for liver donation was similarly grounded in altruism.").

133. Ertman, *supra* note 108, at 17. See Katches et al., *supra* note 125 ("A typical donor produces \$14,000 to \$34,000 in sales for the nonprofits, records and interviews show. But yields can be far greater. Skin, tendons, heart valves, veins and corneas are listed at about \$110,000. Add bone from the same body, and one cadaver can be worth about \$220,000.").

134. Ertman, *supra* note 108, at 15-16.

which attempts to inoculate society against the jarring dissonance of the commodification of body parts.¹³⁵

B. *The Mythical Fragility of Altruism*

When dealing with the human body, the commitment to the rhetoric of altruism is troubling when one realizes the exceptions that are made for market forces to do their work.¹³⁶ Nevertheless, there is a strong attachment to the rhetoric of altruism. Many pure altruists speak of altruism as something fragile that must be carefully nurtured and protected from destruction at the hands of market forces.¹³⁷ This is not entirely unimaginable. In comparing European countries where a market exists for plasma with those where plasma may not be sold, there is a measurable tendency for those in the lowest income quartile not to donate blood when they can sell plasma instead.¹³⁸ This may indicate that where the poor have a commodification option, they are less likely to donate. Even so, that does not indicate that commodification completely stamps out altruism. Several studies indicate that the type of individuals who engage in “unrewarded gifting,” like uncompensated organ donation, are generally unlikely to be dissuaded from an altruistic course of action simply because others are rewarded for the same behavior.

1. “True altruists” see things differently

Joralemon points out that those who champion the rhetoric of altruism connect organ donation to the sorts of acts Americans perform during disasters and accidents: caring responses to personal tragedies The generosity of strangers, the heroism of the person who risks life and limb to

135. *Id.* at 17 (“The language is likely borrowed from blood donation rhetoric, which refers to those giving up their blood as donors regardless of whether they receive money. In both contexts, the terminology masks economic elements of a transaction by suggesting that the people giving up their body parts are doing so out of altruism rather than economic self-interest.”).

136. See Katches et al., *supra* note 125 (discussing specific entities that make huge profits from selling products of donated human bodies).

137. See, e.g., Reed Elizabeth Loder, *Tending the Generous Heart: Mandatory Pro Bono and Moral Development*, 14 GEO. J. LEGAL ETHICS 459, 468 (2001) (arguing that altruistic impulses, if they exist, are more fragile than egoist impulses, and thus that “any dampening influences on altruistic inclinations are significant.”); C. DANIEL BATSON, *THE ALTRUISM QUESTION: TOWARD A SOCIAL-PSYCHOLOGICAL ANSWER* 125-26 (1991) (“[A]ltruistic motivation that blossoms from feeling empathy may be a fragile flower, easily crushed by overriding egoistic concerns.”).

138. HEALY, *supra* note 62, at 84.

rescue those he or she does not know, the coming together of neighborhoods in mutual support at moments of natural destruction¹³⁹

The philosopher and political scientist Kristen Renwick Monroe made a similar finding in her efforts to define altruistic behavior. Monroe interviewed Europeans who took great risks to save Jews during World War II in an attempt to determine what drives “true altruism.” Monroe distinguishes true altruists, those who engage in “behavior intended to benefit another, even when [it] risks possible sacrifice to the welfare of the actor”¹⁴⁰ from those who engage in “quasi-altruistic behavior”—acts which benefit another, but perhaps with benefit to the actor in mind.¹⁴¹ Monroe reached the conclusion that those who engage in true altruism are motivated by a perspective about their fellow human beings and about the world that is measurably different from those who do not engage in altruistic behavior.¹⁴² Monroe describes a perspective of a shared humanity that motivates altruists to take risks on behalf of those they perceive to be in need without taking the risk to self fully into account.¹⁴³

Several studies lend credence to this concept. The 2005 Gallup poll indicates that those who would consider making a living donation to a stranger under the current regime of exclusive altruism are the exception, rather than the rule.¹⁴⁴ This understanding of altruistic giving coincides with

139. Joralemon, *supra* note 103, at 344.

140. KRISTEN RENWICK MONROE, *THE HEART OF ALTRUISM: PERCEPTIONS OF A COMMON HUMANITY* 6 (1996).

141. *Id.* at 7. Monroe's definition of altruism excludes giving that benefits another where “another's welfare is treated as an unintended or secondary consequence of behavior designed primarily to further [the giver's] own welfare.” *Id.* at 6. This definition would relegate donation done through the scholarship incentive program to quasi-altruistic status.

142. *Id.* at 204. Quasi-altruism, as Monroe defines it, matches less restrictive definitions of altruism as posited by other authors. For example, Arthur C. Brooks defines charity as “an expression of ‘affection’” which has “the ability to transform the giver and receiver in unique and important ways.” ARTHUR C. BROOKS, *WHO REALLY CARES: THE SURPRISING TRUTH ABOUT COMPASSIONATE CONSERVATISM* 6-7 (2006). The only restrictions Brooks places on his definition are that charity must be both consensual for and beneficial to both donor and recipient. *Id.* at 6. A third definition of altruism, as applied specifically to organ donation under the current regime, posits that “[d]onation, though perhaps multi-motivational, is conceptually altruistic since no one may be compelled to donate an organ or tissue, either during life or after death.” Rhonda Gay Hartman, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 *HASTINGS L.J.* 1265, 1343 (2000).

143. MONROE, *supra* note 140, at 207. On the other hand, Charles Daniel Batson has conducted research that suggests that altruism decreases as the cost of engaging in altruistic behavior increases. BATSON, *supra* note 137, at 89. If that is the case, then any system of commodification might increase altruism, if an offered incentive presents enticement sufficient to cause the giver to discount the potential risks involved in engaging in altruistic behavior.

144. See GALLUP 2005, *supra* note 37, at 19 tbl.5 (reporting that while 61.7% of respondents identified themselves as very likely to make a living donation to a family member,

a recent study led by Dr. L. Ebony Boulware, which found that those who volunteer to donate a kidney, either for a family member or to a stranger, show an increased willingness to take risks typically associated with kidney donation.¹⁴⁵ As a first cut, the Boulware study seems to corroborate the notion that those who engage in pure altruism or unrewarded gifting—the means of kidney procurement favored rhetorically by law and the transplantation community—see the world differently than the majority of the population. While the Boulware study does not articulate Monroe’s description of a “shared humanity perspective,” it does corroborate her findings regarding a willingness to accept risk to help others. Other studies indicate that the vast majority of kidney donors engage in “‘moral,’ nondeliberative, instantaneous decision-making” rather than “rational decision-making [which] includes multiple steps that focus on gathering relevant information, evaluating alternatives, selecting an alternative, and implementing the decision.”¹⁴⁶ In one study, seventy-eight percent of donors indicated that they “knew right away that they would donate.”¹⁴⁷ In another study of liver lobe donors, the donors themselves specifically commented on the fact that they did not stop to consider and weigh the elements of their decision.¹⁴⁸ Finally, an in-depth psychological evaluation of respondents who self-identified as willing to make a living donation of a kidney to a stranger found a statistically significant difference between the way that participants judged to be truly committed to living donation to a stranger evaluated the “External Costs” associated with kidney donation, and the way that participants judged to be uncommitted weighed those costs.¹⁴⁹ Without overstating the conclusion, these data points suggest that

and 31.3% expressed a willingness to donate to a close friend, only 8.1% of respondents stated they were very likely to make a living donation to someone they do not know).

145. L. Ebony Boulware et al., *Attitudes, Psychology, and Risk Taking of Potential Live Kidney Donors: Strangers, Relatives, and the General Public*, 5 AM. J. TRANSPLANTATION 1671, 1671-72, 1676 (2005) (finding no correlation between psychological illness, depression, or religious affiliation and willingness to donate kidneys, but finding increased willingness to take risks associated with kidney donation among nondirected donors who contacted hospitals and were willing to donate a kidney).

146. Mary Amanda Dew et al., *Psychosocial Aspects of Living Organ Donation*, in LIVING DONOR TRANSPLANTATION 7, 11 (Henkie P. Tan et al. eds., 2007).

147. *Id.* (citing ROBERTA G. SIMMONS, SUSAN D. KLEIN & RICHARD L. SIMMONS, GIFT OF LIFE: THE SOCIAL AND PSYCHOLOGICAL IMPACT OF ORGAN TRANSPLANTATION 242 tbl.8.1 (1977)).

148. Megan Crowley-Matoka et al., *Long-Term Quality of Life Issues Among Adult-to-Pediatric Living Liver Donors: A Qualitative Exploration*, 4 AM. J. TRANSPLANTATION 744, 745 (2004) (reporting that donors made statements such as “‘I think I was on automatic pilot . . . It happened, it happened fast and we did it.’”). This is so, even though liver lobe donation could present a higher risk of harm or impairment than kidney donation. *Id.* at 748.

149. Monica A. Landolt et al., *They Talk the Talk: Surveying Attitudes and Judging Behavior About Living Anonymous Kidney Donation*, 76 TRANSPLANTATION 1437, 1439-40 & tbl.3

those individuals who are willing to engage in unrewarded gifting see the world in a way that is markedly different than the majority of the population. If that intuition is correct, it may also be true that to provide kidneys sufficient to meet transplantation needs, it will be necessary to motivate a different type of potential donor in a different fashion than the one used by the current exclusively altruistic allocation regime. If, on the other hand, it is possible to change perceptions and encourage more people to become true altruists by clinging to the rhetoric of gift, then this may be sufficient reason to prevent commodification.¹⁵⁰ However, attempting to change at least if what Radin identifies as the domino theory of commodification¹⁵¹ (effectively a slippery slope rationale) holds—even partial commodification may move us farther away from a world where we develop an altruistic perspective in the population at large. However, attempting to change the way the general population sees the world might prove a task too drastic for the rhetorical force of altruism.

2. Rewarded gifting need not destroy altruistic giving

If true altruists are individuals who give because of how they see the world, as opposed to rational actors who give because they see something in it for them, perhaps commodification systems designed to reach rational actors will also fail to dissuade true altruists from donating. Monroe's interviewees discussed their feelings about Gestapo agents who helped Jews late in the war as insurance against the coming Nazi defeat.¹⁵² This behavior is quasi-altruism, as Monroe defines it, done for the benefit of the Gestapo agents and not for those they helped. For the interviewees, the universal response was that it was not important to them "that the motives of the helper be pure. . . . [t]he more important thing was that people were saved, not that they were saved for the right reasons."¹⁵³ This suggests that, even though those who give with impure motives benefit from their quasi-altruistic giving, the pure altruist remains willing to give so long as people

(2003) (reporting on an in depth interview of fifty-two participants who identified themselves as willing to make a living donation to a stranger in a previous exam, and measuring a statistical significant variation in table 3 ($P > 0.0001$) in the way committed and uncommitted participants weighed. "[T]he external costs imposed on the donor, such as financial costs, extensive medical tests, fears associated with undergoing major surgery, potential health problems, the experience of pain, and the fear that it all might be for naught if the transplant is not successful." *Id.* at 1439).

150. If the domino theory of commodification holds true, see RADIN, *supra* note 111 at 103, then even partial commodification may move us farther away from a world where the population at large develops an altruistic perspective.

151. See RADIN, *supra* note 111, at 103.

152. MONROE, *supra* note 140, at 146.

153. *Id.*

receive the help they need, and regardless of whether the pure altruist herself stands to benefit. For the pure altruist, Monroe finds that altruistic behavior is both ingrained and somewhat subconscious.¹⁵⁴ If the risk of death for themselves and their families did not dissuade true altruists from saving the lives of Jews in occupied Europe, why would an incentive like the scholarship proposal dissuade those already willing to donate kidneys to a fatally ill recipient?

The Gallup Poll and the Bryce study discussed earlier suggest that while those who are unlikely to donate reported some negative reaction to commodification systems, those who were already predisposed to donate reported that commodification systems made them more likely to donate, not less likely.¹⁵⁵ In an earlier 1993 Gallup Poll, non-Caucasian respondents who identified themselves as opposed to deceased donation of their organs became more opposed when asked about the possibility that their family would receive financial incentives for their organs at death.¹⁵⁶ For respondents contemplating deceased donation, this may stem in part from a concern that their families will be convinced to “pull the plug” on life-preserving technologies to early at the behest of the attending physician.¹⁵⁷

The Bryce study suggests that partial commodification regimes are more acceptable to the public than unrestrained commodification. For example, funeral benefits, hospital expenses and travel reimbursement for family members of deceased donors, all types of rewarded gifting,¹⁵⁸ received a strong positive response, while charitable cash donations in the donor’s name were received less favorably, and direct payment for organs, i.e., unrestricted commodification, was the least favored option.¹⁵⁹ Like the other types of rewarded gifting, scholarships and financial aid occupy an

154. *Id.* at 148-49 (noting that the interviews detected “a consistent pattern of [altruistic] behavior, that there is indeed such a thing as the ‘altruistic personality,’ in which the habit of helping others has become so ingrained over the years that the helping response is virtually automatic.”).

155. Bryce et al., *supra* note 47, at 3002 (reporting that for respondents who identified themselves as registered donors, every benefit program with the exception of direct payment increased the likelihood that the registered donors would register again); GALLUP 2005, *supra* note 37, at 24 fig.12 (“Financial Incentives and Deceased Organ Donation 1993-2005”).

156. GALLUP 1993, *supra* note 36, at 43 tbl.32, 44.

157. GOODWIN, BLACK MARKETS, *supra* note 2, at 50 (citing a survey respondent who indicated that “a lot of people feel that your organs will be harvested before you actually die.”).

158. See generally Daar, *supra* note 7, at 187 (noting that reward gifting includes compensation for loss of wages, hospitalization and other related expenses).

159. Bryce et al., *supra* note 47, at 3001 (noting that this disparity did not amount to a negative reaction by respondents, even to outright commodification which was supported by fifty-three percent of respondents).

important rhetorical space between outright commodification and altruistic gift, which suggests that the proposed scholarship incentive would be more palatable to donors and the public, and less likely to trigger an adverse social reaction than an unrestricted cash award.

C. *The Rhetorical Power of Scholarship Incentives*

Academic scholarships are spoken of in the language of gift. Solicitations for donations from university alumni are typically couched as an invitation to contribute a gift to the alma mater.¹⁶⁰ Those pleas rarely acknowledge the market exchange qualities of charitable solicitation,¹⁶¹ even though the donation of a financial gift to a qualified university can provide the donor with significant tax and reputation benefits. For donors who contribute large status-enhancing gifts, the power of the gift to signal the status of the giver is tied directly to its gift rhetoric—because scholarships and endowments are spoken of as gifts, couched in the rhetoric of altruism, they allow the status-seeker to be seen as someone who actually is charitable, instead of merely someone seeking to call attention to her considerable wealth.¹⁶² To speak of these donations in market language destroys that perception. The behavior of donors making status-enhancing contributions, including the endowment of scholarships, suggests that these scholarships evidence the rhetorical power of gift.

Instructions for a recent survey distributed by the California State University Office of the Chancellor to various departments to measure contributions from donors took pains to distinguish between voluntary giving (which the instructions refer to as “Voluntary Support of Education”)¹⁶³ and

160. See, e.g., Daniel Mark Fogel & James Pizzagalli, *Scholarship: The Gift of a Lifetime—A Message from President Daniel M. Fogel and Chairman of the Board James Pizzagalli* (Nov. 1, 2004), at www.uvm.edu/~campaign/media/gallery_news_cu.php?return_URL=%2F%7Ecampaign%2Fnewsevents.php&SID=&G_ID=news&GI_ID=85YMywY4icLoe1v&GI_I=43 (last visited Apr. 9, 2009) (stating that “[a] gift to scholarships at UVM is truly the gift of a lifetime.”).

161. For example, a recent publication from the University of Chicago Law School mentioned the words gift, giving, or its synonyms like endow and provide, forty-nine times, and the financial, tax, or reputational benefits to the donor twenty-five times. THE UNIVERSITY OF CHICAGO LAW SCHOOL, ELEMENTS OF THE CENTENNIAL CAPITAL CAMPAIGN FOR EXCELLENCE (2004).

162. David Gamage & Allon Kedem, *Commodification and Contract Formation: Placing the Consideration Doctrine on Stronger Foundations*, 73 U. CHI. L. REV. 1299, 1332 (2006).

163. CAL. STATE UNIV. OFFICE OF THE CHANCELLOR, ADVANCEMENT REPORTING AND DATA COLLECTION PROCESS 5 (2008), available at www.calstate.edu/universityadvancement/intranet/policies-procedures/documents/advancement_data_instructions.pdf (last visited Apr. 9, 2009) (“What is a Gift? A contribution received by an institution for either unrestricted or restricted use in the furtherance of the institution for which it has made no commitment of resources or services other than, possibly, committing to use the gift as the donor specifies.”).

quid pro quo exchanges.¹⁶⁴ While the instructions are careful to ensure that there is no quid pro quo for donors, it is equally clear that the California State University system goes to some lengths to recognize many of its donors.¹⁶⁵

As an examination of a recent philanthropic solicitation from the University of Chicago Law School suggests, the rhetoric used to solicit philanthropic giving to an educational institution is multifaceted, simultaneously appealing to a sense of duty to recompense the institution for what one was given; a sense of belonging for those who elect to contribute; a sense of quid pro quo—that the donations made to the university are an investment which will provide some sort of psychic, if not financial return; and lastly, a sense of obligation based on the need of the institution. There is surprisingly little discussion of possible tax benefits to the giver, especially considering the reputation of the University of Chicago as a champion of law and economics¹⁶⁶ and the rational actor model.¹⁶⁷

The contribution is a nonreciprocal transfer in that there is no implicit or explicit statement of exchange, purchase of services, or provision of exclusive information. If the donor receives benefits in return for the contribution, the amount of the gift recorded and reported is reduced by the fair market value of all benefits given, according to U.S. Internal Revenue Service regulations. The institution has no obligation to report to the donor how the gift is used or invested; but institutions are not prevented from providing such reports as part of donor stewardship.”).

164. *Id.* Characteristics of exchange (quid pro quo) transactions to be excluded from the VSE survey:

- The funding entity initiates the project, participates actively in determining how funds will be spent, and defines performance objectives.
- Proprietary results belong to the funding entity, in whole or in part, after the work is completed.
- Funds provide goods or services for the funding entity.
- Results of the work have a specific commercial value for the funding entity that equal or exceed the amount of the grant.
- The funding entity retains intellectual property rights (i.e. copyrights or exclusive knowledge of outcomes).
- The university gives up the benefits of the research to the funding entity.

Id. at 5-6.

165. See, e.g., San Diego State University: Contribution Highlights, available at www.calstate.edu/universityadvancement/reports/0405externalreport/campus/san_diego.pdf (last visited Apr. 9, 2009) (“The San Diego State Entrepreneurial Management Center received a \$1 million pledge from the Lavin Family Foundation for unrestricted current use support. The gift will be used to build programming, support research and assist students pursuing their entrepreneurial studies.”).

166. See, e.g., Samuel J. Levine, *Richard Posner Meets Reb Chaim of Brisk: A Comparative Study in the Founding of Intellectual Legal Movements*, 8 SAN DIEGO INT’L L.J. 95, 108 (2006) (noting “the significance of law and economics as a late twentieth century movement, and of the importance of Posner and the Chicago school as leading proponents . . .”).

The law also conceives of scholarships as something other than market transactions, even when many, if not all, scholarships are founded on an implicit, if not explicit, bargained-for exchange. The Internal Revenue Code generally treats academic scholarships as non-taxable income,¹⁶⁸ but where there is a quid pro quo involved—for example, “any amount received which represents payment for teaching, research, or other services by the student required as a condition for receiving the qualified scholarship”¹⁶⁹—scholarships are to be treated as valuable consideration and taxed as income.¹⁷⁰

The tax liability articulated in the Internal Revenue Code is not necessarily an operational reality at the university level. For example, most scholarships are not taxed, even though the majority of them include preconditions to qualify for academic scholarships, and conditions attached to the continuation of such a scholarship, including maintaining a certain grade point average¹⁷¹ and not engaging in illegal activity.¹⁷² In essence, where academic scholarships are involved, the Internal Revenue Service turns a blind eye to many bargained-for exchanges.

Athletic scholarships are also treated differently than market transactions,¹⁷³ even though the quid pro quo of the athletic scholarship is a

167. Frank H. Easterbrook, *Workable Antitrust Policy*, 84 MICH. L. REV. 1696, 1706 (1986) (acknowledging that the practitioners of the Chicago school method of law and economics “apply a neoclassical model that assumes rational actors and an inevitable drive toward production at marginal cost.”).

168. Internal Revenue Code (I.R.C.) § 117(a) (2008).

169. I.R.C. § 117(c)(1) (2008).

170. WILLIAM A. KLEIN ET AL., *FEDERAL INCOME TAXATION* 92 (14th ed. 2006).

171. For example, students in Georgia who receive the HOPE Scholarship, which provides free tuition at Georgia colleges and universities, continue to qualify for the Scholarship so long as they maintain a 3.0 grade point average throughout their postsecondary studies. GACollege41, *Maintaining Eligibility for the HOPE Scholarship*, at www.gacollege411.org/FinAid/ScholarshipsAndGrants/HOPEScholarship/maintaining.asp#a2 (last visited Apr. 9, 2009).

172. See, e.g., NORTHWEST COLLEGE, NJCAA STUDENT-ATHLETE CODE OF CONDUCT (2007), available at www.northwestcollege.edu/athletics/docs/coc_njcaa.pdf (last visited Apr. 9, 2009) (noting that student-athletes will be suspended or dismissed from school for any arrest other than a minor traffic offense). Note, however, that negative requirements are not necessarily viewed as a quid pro quo, according to some commentators of contract law. Compare *Ricketts v. Scothorn*, 77 N.W. 365, 366-67 (Neb. 1898) (recognizing the lack of consideration in a promise from grandfather to granddaughter to support her financially should she restrain from working, but enforcing the promise on the grounds of promissory estoppel) with *Hamer v. Sidway*, 27 N.E. 256 (N.Y. 1891) (holding that refraining from the use of liquor or tobacco is sufficient consideration for a promise to pay a sum of money at a later date).

173. Rev. Rul. 77-263, 1977-2 C.B. 47 (stating that athletic scholarships are not taxable income because “the university requires no particular activity of any of its scholarship

well-documented reality.¹⁷⁴ This determination by the IRS ignores the reality that athletes who are not productive (or whose style of play does not suit the needs of a new coach) can find themselves cut from a university's athletic program without any legal recourse.¹⁷⁵ While athletic scholarships are treated as valuable consideration in contract disputes between student athletes and universities,¹⁷⁶ the IRS simultaneously engages in the legal fiction that athletes are not "required [to compete] as a condition for receiving the qualified scholarship."¹⁷⁷ It is unclear why the IRS does not tax athletic scholarships despite their nature of providing a bargained-for exchange. What is clear is that there is some incongruity between the tax treatment of these scholarships and their treatment in the course of contract disputes. Both academic and athletic scholarships¹⁷⁸ occupy a unique rhetorical middle ground between unrestricted commodification and altruistic giving.

Providing financial incentives in the form of a scholarship occupies a different rhetorical space than that of a raw financial incentive. An incentive program that naturally leads to a discussion of financial incentives in terms of gift language preserves the rhetoric of altruism and protects space for altruistic meaning.

recipients. Although students who receive athletic scholarships do so because of their special abilities in a particular sport and are expected to participate in the sport, the scholarship is not cancelled in the event the student cannot participate and the student is not required to engage in any other activities in lieu of participating in the sport.").

174. Sean M. Hanlon, Comment, *Athletic Scholarships as Unconscionable Contracts of Adhesion: Has the NCAA Fouled Out?*, 13 SPORTS LAW. J. 41, 43-45 (2006) (describing the misperception that student-athletes are protected for all four years of scholarship eligibility, and the reality that NCAA rules permit universities to deny renewal of an athlete's scholarship without cause if reasonable notice is provided).

175. See, e.g., *Taylor v. Wake Forest Univ.*, 191 S.E.2d 379, 382 (N.C. Ct. App. 1972) (holding that where a student-athlete did not participate in sports when he was both academically and physically able to do so, the school was justified in canceling his scholarship), *cert. denied*, 192 S.E.2d 197 (N.C. 1972).

176. The following courts have acknowledged the contractual nature of the relationship between universities and scholarship athletes: *Ross v. Creighton Univ.*, 957 F.2d 410, 416-17 (7th Cir. 1992); *Jackson v. Drake Univ.*, 778 F. Supp. 1490, 1493 (S.D. Iowa 1991); *Barile v. Univ. of Va.*, 441 N.E.2d 608, 615 (Ohio Ct. App. 1981); *Colo. Seminary (Univ. of Denver) v. NCAA*, 417 F. Supp. 885, 895 (D. Colo. 1976); *Begley v. Corp. of Mercer Univ.*, 367 F. Supp. 908, 909-10 (E.D. Tenn. 1973); *Taylor*, 191 S.E.2d at 38. *Contra* *Rensing v. Ind. State Univ. Bd. of Trs.*, 444 N.E.2d 1170, 1174-75 (Ind. 1983) (holding the relationship between student athletes and the university is not contractual).

177. I.R.C. § 117(c)(1) (2008).

178. See *infra* Part V.

IV. SCHOLARSHIP INCENTIVES REDUCE COERCIVE PRESSURE AND EXPLOITATIVE EFFECTS

The previous Part of this article provides the rhetorical justification for the scholarship incentive, and suggests that it might be an acceptable means of encouraging donation without triggering hostile reactions from the public. However, public acceptance of the scholarship incentive does not resolve questions of coercion and exploitation. Critics of commodification regimes frequently argue that paying donors to part with their kidney will exploit the donor's poverty or lack of economic or employment opportunities and create coercive pressure that the donor cannot resist. These coercive effects would impair the decisional capacity of donors to correctly weigh the costs and benefits of kidney donation. Implicit in that argument is the notion that the money offered in exchange for a kidney would not adequately compensate the donor for taking the risk involved. Market transfers may provide net harm to those donors that weigh financial considerations more heavily than concerns about long term health and well-being. However, even if unfettered cash compensation for kidneys would impair the decisional capacity of potential donors, the structure of the proposed scholarship incentive dissipates that coercive pressure.

The scholarship incentive is most likely to attract "emerging adults," a population of potential donors aged eighteen to twenty-five,¹⁷⁹ often viewed as vulnerable to coercion.¹⁸⁰ By examining literature on availability heuristics, brain morphology, and analogous existing legal structures, this Part argues that emerging adult populations have sufficient decisional

179. Jeffrey Jensen Arnett, *Emerging Adulthood: A Theory of Development from the Late Teens Through the Twenties*, 55 AM. PSYCHOLOGIST 469, 470-71 (2000).

180. One might wonder whether the scholarship program would unduly benefit male scholar-donors, who need not be concerned about the health effects of donation on a subsequent pregnancy, but the medical literature finds no significant correlation between living kidney donation and complications with subsequent pregnancy. See Lucile E. Wrenshall et al., *Pregnancy After Donor Nephrectomy*, 62 TRANSPLANTATION 1934 (1996) (reporting on forty-five gestations and/or pregnancies among thirty-three living kidney donors and observing that donor nephrectomy did not introduce complications in excess of those experienced by the general population); J.W. Jones et al., *Pregnancy Following Kidney Donation*, 25 TRANSPLANTATION PROC. 3082 (1993) (reporting that fourteen female living kidney donors subsequently had twenty-three successful full-term pregnancies, and that for eight women who experienced full-term pregnancy both pre-and post-donation, "there were no differences in the complications or results of [the] pregnancies before and after kidney donation . . ."). See also M.M. Shekhtman & S.B. Petrova, 72 TERAPEVTICHESKĬ ARKHIV 39 (2000) (concluding that a "[s]olitary kidney is not contraindication to pregnancy," but that "[o]bstetric complications arose more frequently than in women with two kidneys") (Russian article, abstract available in English, available at www.ncbi.nlm.nih.gov/pubmed/10900647?ordinalpos=2&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum (last visited Apr. 9, 2009)).

capacity to correctly weigh the costs and benefits of donating a kidney, even in view of the substantial reward of an educational scholarship, because of the nature of the benefit provided by an educational scholarship. This Part first establishes some terms of the debate, explaining why cash rewards might have a coercive influence that overwhelms the decisional capacity of underprivileged populations. The Part next explains the coercive effects already built into the current kidney allocation regime. This Part concludes by describing how the scholarship incentive can protect the capacity of donors to make an informed, voluntary decision to donate.

A. *Unfair Transactions and Background Inequities*

Risk, as defined by Corinna Alberg and collaborators, is “[t]he possibility of beneficial and harmful outcomes and the likelihood of their occurrence in a stated timescale.”¹⁸¹ Risk assessment is thus the process of determining the likelihood that harms and benefits will occur when engaging in a particular course of action. Mike Titterton, who studies health care and social work, defines risk taking as “a course of purposeful action based on informed decisions concerning the possibility of positive and negative outcomes of types and levels of risk appropriate in certain situations.”¹⁸² By these definitions, the key to assuring that risks are correctly assessed is making sure that the individual assessing the risk has all necessary information to make a correct decision.

In the field of organ donation, medical ethics requires that a donor has the competence to give informed consent before the donation can move forward. Medical ethics requires competence not in the abstract, but competence to decide to undertake a particular medical risk, called “decisional capacity.”¹⁸³ For the purposes of this article, decisional capacity is the competence to recognize the risks and benefits involved with donating a kidney, and to make an informed choice whether or not to do so. Some argue that the decisional capacity required to give informed consent to donation is compromised by the introduction of financial incentives.¹⁸⁴ The standard argument against commodification is that markets for kidneys will have a coercive effect, strong enough to impair the decisional capacity of donors. Implicit in that argument is an associated notion that the money offered in exchange for a kidney would not fully compensate the donor for

181. CORINNA ALBERG ET AL., *LEARNING MATERIALS ON MENTAL HEALTH: RISK ASSESSMENT* 9 (1996).

182. MIKE TITTERTON, *RISK AND RISK TAKING IN HEALTH AND SOCIAL WELFARE* 25 (2005).

183. JUDITH C. AHRONHEIM ET AL., *ETHICS IN CLINICAL PRACTICE* 29 (2d ed. 2000).

184. The ethicist Alan Wertheimer recounts that one bioethicist likens “‘dangling thousands of dollars in front of a poor person . . . [to] putting a gun to someone’s head and telling them to do something.’” ALAN WERTHEIMER, *COERCION* 68 (1987).

taking the risk involved, or that it would compel a potential donor to take a risk greater than she otherwise would undertake for a commensurate reward.

There are ways in which financial incentives can compromise decisional capacity to donate. First, the introduction of money may cause prospective donors to engage in faulty risk assessment. Two different psychological phenomena, hyperbolic discounting and availability heuristics, help explain this possibility. Hyperbolic discounting is a behavioral economics finding that people prefer smaller, immediate payoffs to larger, long-term payoffs. When asked to balance cash in hand against temporally distant future benefit or risk—such as health complications which can follow kidney donation—individuals typically discount the value of later benefit or risk because it is removed in time.¹⁸⁵ However, when measuring two distinct future values, test subjects tend to pick the larger of the two values, even when it is removed farther in time than the first value. Addicts¹⁸⁶ tend to demonstrate a high occurrence of hyperbolic discounting, often steeply discounting the long-term consequences of a currently desired behavior.

The availability heuristic is a rule of thumb for decision making, where an outcome seems more likely when it is more easily brought to mind, i.e., more available.¹⁸⁷ A cash payment could exert a distorting effect on decisional capacity, because an immediate cash compensation is simply more “available”—i.e., more easily brought to mind—than the risks presented by donating a kidney, unless the donor is familiar with experiences that other donors have had. The value of money is more readily available in making the risk assessment than the noneconomic, psychic benefits associated with altruistic giving. Thus, weighing the long-term benefits of the health of the recipient against the potential long-term risks to the health of the donor will lead to one type of risk calculation, while weighing a future health risk against cold hard cash will tend to lead to an entirely different evaluation.

185. Andres Raineri & Howard Rachlin, *The Effect of Temporal Constraints on the Value of Money and Other Commodities*, 6 J. BEHAVIORAL DECISION MAKING 77, 80 (1993) (measuring the effect where test subjects were asked to value lottery winnings at a particular period in the future against a smaller, immediate amount in the present).

186. See, e.g., Andrew Green, *Self Control, Individual Choice, and Climate Change*, 26 VA. ENVTL. L.J. 77, 92-93 (2008) (“Given hyperbolic discounting, delayed penalties or rewards may be ineffective to deal with addiction. Individuals discount the delayed and uncertain reward or penalty more than the immediate gratification from the choice, so immediate rewards or penalties are likely more effective.”).

187. Amos Tversky & Daniel Kahneman, *Availability: A Heuristic for Judging Frequency and Probability*, 5 COGNITIVE PSYCHOL. 207, 208 (1973) (“A person is said to employ the availability heuristic whenever he estimates frequency or probability by the ease with which instances or associations could be brought to mind.”).

A second and related way in which cash compensation could compromise decisional capacity is by taking advantage of the unfortunate background circumstances of the donor. While cash may be more salient than psychic benefits to any single individual, it is likely to be much more salient to an individual who comes from a background of poverty than one who comes from a background of wealth.¹⁸⁸ This understanding is not unlike the Biblical story of Esau, willing to sell his birthright to his brother Jacob for a mess of pottage to satisfy his immediate hunger. In heuristic terms, the “mess of pottage” Esau craved was far more salient than the birthright, which Esau “despised,” or undervalued, in part because of its temporal remoteness.¹⁸⁹ A more modern example is the willingness of lottery winners to exchange their future winnings for a cash sum, even when doing so reduces the total amount of money the winner receives.¹⁹⁰

188. Interestingly, the presumption that the scholarship incentive will exert undue coercive pressure due to the disadvantaged backgrounds of students might not be universally true. Several Ivy League schools have recently provided grants for, or waived tuition for, students whose families make less than \$100,000 per year. See *Brown Ends Tuition for Lower-Income Students*, N.Y. TIMES, Feb. 25, 2008, at <http://query.nytimes.com/gst/fullpage.html?res=9402E6DE103AF936A15751C0A96E9C8B63&partner=rssnyt&emc=rss> (last visited Apr. 9, 2009) (reporting that Brown, Harvard, Yale, Dartmouth, and Stanford have all replaced loans for lower income students with grants); Larry Gordon, *Stanford Offers Middle-Class Tuition Break*, L.A. TIMES, Feb. 21, 2008, at <http://articles.latimes.com/2008/feb/21/local/me-collegeaid21> (last visited Apr. 9, 2009) (reporting that Stanford will eliminate tuition for students whose families make less than \$100,000 per year). If, as currently conceived, the scholarship incentive pays the costs of attending any university to which the donor can get admitted, then students in poverty who qualify for schools like Brown and Stanford will get no benefit from the incentive: it is the well-heeled student who would stand to save the tuition (currently \$36,000 per year at Stanford) by taking advantage of the scholarship incentive. However, those programs do not carry very far down the line at academic institutions, because few schools have endowments that schools like Princeton and Harvard have amassed. Karen W. Arenson, *Soaring Endowments Widen a Higher Education Gap*, N.Y. TIMES, Feb. 4, 2008, at A14 (reporting that Princeton, for example, boasts a \$15.8 billion endowment, while Harvard's endowment grew by \$5.7 billion last year). So the top Ivy League schools might change the tax bracket of potential donors most attracted to the scholarship incentive.

189. Genesis 25:29-34.

190. In Massachusetts, for example, several lottery winners sold off their payments to a company for a lump sum, usually giving up between seven and twenty percent of their future income stream. See Bruce Mohl, *Hey, Lottery Winner, Want a Lump Sum? Let the Game Begin*, BOSTON GLOBE, Apr. 10, 2005, at E11. California's first lump sum lottery payment paid roughly fifty cents on the dollar. Jamie Beckett, *Lotto Prize Brokers Hit Jackpot: Companies Buy and Resell Annual Payments from Winners*, SAN FRAN. CHRON., Apr. 11, 1998, at D2.

Studies from India¹⁹¹ and Iran¹⁹² indicate that vendors who sold a kidney to get out of debt experienced a net reduction in both health and welfare after the sale. It seems clear from these studies that a desire to meet short-term financial difficulties creates pressure to engage in any number of potentially lucrative activities, and that desperate financial straits may impair decisional capacity. However, the Iranian study also noted “an extraordinary lack of information about preservation of the remaining kidney” and a marked unwillingness or perceived inability to receive post-operative care.¹⁹³ Lack of education put vendors in a situation where they could do little other than physical labor.¹⁹⁴ Few had insurance, and many lost work during the post-operative period.¹⁹⁵ Finally, the Iranian vendors suffered a significant amount of both internal and external psychological stigma related to their decision to sell a kidney. For example, many vendors reported that in arguments on unrelated matters, the opponent would refer to the vendor with the invective, “you kidney seller,” to which the vendor had no retort, resulting in the vendor’s shame and embarrassment.¹⁹⁶ These data points indicate that there is a real social weight and rhetorical power found in the difference between the donation and sale of kidneys. In Iran, it is often a family member to whom the vendor owes money who puts pressure on the donor to sell the kidney.¹⁹⁷ Finally, vendors were preoccupied with the loss of their kidney in part because they knew if they lost the second kidney, they could not afford to purchase one on the open market.¹⁹⁸

These studies suggest several important safeguards that must be built into the scholarship program. First, the scholarship program must not circumvent a careful psychological assessment of potential donors, and of the family support structure in place for post-operative care. Second,

191. Goyal, *supra* note 28, at 1591-92.

192. Javaad Zargooshi, *Quality of Life of Iranian Kidney “Donors,”* 166 J. UROLOGY 1790, 1790-91 (2001) (reporting that in interviews with 307 Iranian kidney vendors, significant portions of the population reported dissatisfaction with their choice to sell a kidney, concerns about their physical health and ability to work, and showed high incidence of depression). Interestingly, the entire reported donor population had no more than a high school education, and a significant number (thirty-five percent) were identified as illiterate. *Id.* at 1791, tbl.1. It is hard to dispute that in the case of the Iranian vendors, severe poverty drove them to a decision they thought was necessary at the time, and the minority of vendors who reported willingness to vend again stated they would do so “because there was absolutely no other way to provide short-term support for their urgent financial need.” *Id.* at 1796.

193. *Id.* at 1791.

194. *Id.* at 1795.

195. *Id.* at 1794.

196. *Id.*

197. Zargooshi, *supra* note 192, at 1795.

198. *Id.* at 1796.

reasonable post-operative care must be provided to donors, regardless of income, insurance, or other factors. Third, it is crucial that donors applying for the scholarship program are provided with sufficient information to make an informed consent, specifically about long term health risks for the loss of the second kidney. Fourth, all donors (both altruistic and scholarship) should be awarded priority for obtaining a kidney in the case of a future accident or disease. Finally, there must be a mechanism which provides equally for rich and poor potential recipients to be able to obtain a kidney. The method of distributing kidneys cannot depend on the ability of the recipient to pay. The perception that poverty cuts vendors off from kidneys if they should face a future need seems to add to the emotional and psychological harms that vendors suffer.¹⁹⁹

B. Coercive Effects of the Current Regime

Any system of commodification could exploit the background circumstances faced by potential donors.²⁰⁰ On one level, the scholarship incentive is no different. Those who are financially well off, or who can afford the best education available, will not be attracted to the proposed scholarship incentive. Open market advocates argue that preventing underprivileged parties from selling that which they possess hurts them far worse than any potential unfairness that background circumstances introduce into the underlying bargain.²⁰¹ In addition, the current regime of exclusive altruism also exploits vulnerable groups based on background situations outside the control of the transplantation industry. The following examples are illustrative.

First, the current shortage of kidneys available for transplantation creates background pressure which drive wealthy potential recipients to third world countries where there is little in the way of regulation, information, or aftercare provided for kidney vendors.²⁰² In some of those countries,

199. *Id.*

200. ALAN WERTHEIMER, EXPLOITATION 27 (1996) (discussing how, for example, "poor background circumstances" might be understood to "force" a recruit to join the military because there is no better option).

201. *Id.* at 111 (noting that even if background conditions compromise the voluntariness of a person's choice in accepting an offer, "it is arguable that it is the background conditions that are the problem and not the offer that allows [the person] to improve on those background conditions. The offer is still a positive good.").

202. Curt S. Koontz & Joseph B. Cofer, *What Price Should Be Paid for Organs?*, 61 CURRENT SURGERY 419, 420 (2004) (reviewing the study of Indian kidney vendors by Goyal et al., (see *supra* note 28) and noting that in light of the reality of a vibrant black market in third world countries, "[Goyal's] study could support the notion that developed countries . . . should lead the way in setting standards for compensating 'donors'. . . . Otherwise, donors may be exploited and their health compromised in underdeveloped countries with a black market.").

kidneys are often obtained in ways that actively exploit the population (for example, upfront cash donation without adequate information or follow-up care),²⁰³ or are taken by force. In one recent case, the mastermind behind a kidney procurement racket recruited men in India for construction work, had them forcibly anesthetized, and then removed their kidneys without consent for transplant into foreign recipients.²⁰⁴

Second, the family dynamic creates significant coercive pressure on related donors,²⁰⁵ and shortages inherent in the current kidney procurement system create pressures that coerce the participation of minor donors. Desperate family members occasionally pressure small children or incompetents to donate, and judges sign off on the donation as being in the best interest of the donor, because of the familial relationship of the donor to the recipient.²⁰⁶ Courts justify the use of children and incompetent family members as organ suppliers because of the perception that there are no other options. For example, the Texas Court of Civil Appeals found a fourteen year old girl with Down's Syndrome could not voluntarily consent to donating her kidney to her brother,²⁰⁷ nor could her mother consent for her on the grounds that the donation was a therapeutic medical procedure that benefited the donor.²⁰⁸ Nevertheless, the court upheld a trial court decision allowing the donation on the grounds that the girl would receive substantial psychological benefits from making the donation because it would preserve the life of her brother, with whom she had a close relationship.²⁰⁹

The transplantation community is now recognizing the coercive effects that some subordinate relationships might have on the potential donor, such

203. See *supra* Part IV.A.

204. Rama Lakshmi, *India Uncovers Kidney Racket: Poor Laborers Were Victims of Organ-Trafficking Network*, WASH. POST, Jan. 30, 2008, at A11 (reporting that the mastermind of a recently disrupted Indian kidney racket "used to charge about 15 lakh rupees [\$37,500] from rich patients around the world and pay about 50,000 rupees [\$1,270] to the laborer after forcibly removing the kidney.").

205. See B. Larijani et al., *Rewarded Gift for Living Renal Donors*, 36 TRANSPLANTATION PROC. 2539, 2540 (2004) ("The people who voluntarily donate an organ to a relative are sometimes subject to greater coercion than those who sell their organs, because of internal pressure and pressure from other family members to save the loved one.").

206. *Little v. Little*, 576 S.W.2d 493, 498-500 (Tex. Civ. App. 1979); *Strunk v. Strunk*, 445 S.W.2d 145, 146, 149 (Ky. Ct. App. 1969); Goodwin, *The Body Market*, *supra* note 10, at 635. But cf. *Curran v. Bosze*, 566 N.E.2d 1319, 1344-45 (Ill. 1990) (denying the petition of the noncustodial father of twin boys to have them tested for compatibility to donate bone marrow to their half brother. The brother died before a donor could be found.).

207. *Little*, 576 S.W.2d at 493-95.

208. *Id.* at 495.

209. *Id.* at 500.

as employer-employee or teacher-student,²¹⁰ but in other cases they underestimate the coercive effect of subordinate family relationships.²¹¹

C. *The Scholarship Incentive Protects the Capacity to Consent*

An oft-repeated refrain regarding markets for organs is that financial incentives coerce behavior in a way that a regime of altruistic giving will not.²¹² This claim has not gone undisputed,²¹³ but let us assume that this concern is valid at its extreme: an unrestricted cash-for-kidney system would exert sufficient coercive pressure that poor people would allow themselves to be exploited, and additionally miscalculate the risks involved in living donation.²¹⁴ This Part of the article argues that the coercive pressure which may be inherent in a cash-for-kidney market system will be ameliorated by the proposed scholarship regime.

1. Intertemporal choices and scholarship incentives

One recent study by neuroscientist Samuel McClure and his collaborators suggests that the cognitive mechanisms of the brain explain hyperbolic discounting. The McClure study measured the cognitive mechanisms of the brain, and found they respond differently to the promise of immediate monetary reward than they do to temporally remote benefits.²¹⁵ When participants were offered a choice between an immediate monetary reward and a greater reward at a future point in time, those participants who selected the immediate reward displayed increased activity in the limbic system, the part of the brain connected with impulse decisions and addiction. When selecting between two monetary rewards at a future point in time, where the reward closer in time was less than the reward

210. Dew et al., *supra* note 128, at 1048 (reporting the recommendations of seventy transplantation professionals regarding psychological evaluations for nondirected altruistic donors).

211. *Id.* at 1049 tbl.2 (identifying “[s]ubordinate relationship (e.g. employee/employer) or other evidence of coercion” as a factor with “heightened importance for unrelated donors”). The Dew Guidelines also express concern that nondirected donors are more likely to fall prey to an exaggerated emotional appeal than directed donors, concluding that directed donors were more likely to have made the decision to donate “against a backdrop of ongoing education about treatment options and potential treatment outcomes.” *Id.* at 1049.

212. See, e.g., Holloway, *supra* note 110, at 153 (arguing that payment for organs would result in the dehumanization and degradation of the poor, who are “the ones who need money badly enough to resort to the sale of their own body parts.”).

213. See, e.g., Eugene Volokh, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. 1813, 1841 (2007) (arguing that the risks involved with organ donation are not sufficient to justify the current ban).

214. Goyal et al., *supra* note 28, at 1591-92.

215. Samuel M. McClure et al., *Separate Neural Systems Value Immediate and Delayed Monetary Rewards*, 306 SCIENCE 503, 503 (2004).

further in time, the selection process was correlated with increased activity in the lateral prefrontal cortex, the posterior parietal cortex, and associated structures, which are connected with the ability to plan, make abstract decisions, and engage in rational deliberation.²¹⁶ In addition, decisions which were more difficult than others (where difficulty was measured by the time it took to make the decision) tended to trigger more significant responses from the prefrontal cortex structures.²¹⁷ These findings suggest that immediate cash compensation elicits impulse decisions in a way more likely to impair decisional capacity than a delayed benefit like the proposed scholarship incentive.

If this literature is correct, then the scholarship incentive would be, by its nature, more likely to trigger prefrontal response mechanisms and less likely to trigger responses in the limbic system, which are associated with impulse decisions. However, the scholarship incentive also raises a particular concern because of its admitted target population: "emerging adults," the population between the ages of eighteen and twenty-five.²¹⁸

2. Do emerging adults have the capacity to provide informed consent?

Donor age has increased over the past decade. Unfortunately, the older the donor, the more likely that renal function has declined.²¹⁹ Medically speaking, emerging adults are perfect donor candidates.²²⁰ However, emerging adult donors might also be thought to be more susceptible to an unfair or coercive transaction than more mature adults.

The potential benefits that the proposed scholarship program would provide the donor population can be illustrated in part by looking to the various G.I. College Bills. There too, the typical beneficiaries are emerging adults. The economic benefits of the G.I. Bill for society on the whole are generally uncontested.²²¹ Scholars estimate that the G.I. Bill returned

216. *Id.* at 504-05.

217. *Id.* at 505 & fig.2, 506 fig.3 (measuring in figure 3 significant increases in brain activity in the right dorsolateral prefrontal cortex, right ventrolateral prefrontal cortex, the right lateral orbitofrontal cortex, and the inferoparietal cortex).

218. Arnett, *supra* note 179, at 470-71.

219. McCauley et al., *supra* note 66, at 28.

220. *Id.* ("[T]he ideal potential donor is one who is young and in perfect health."). The lack of kidneys available through current procurement means has required relaxing standards for what constitutes the ideal donor. *Id.* Thus, inasmuch as we increase living donation, we may enable hospitals to be more selective, with the associated benefit that donors with poorer health, and less likely to make a successful donation, are less likely to be selected for donation.

221. MICHAEL J. BENNETT, WHEN DREAMS CAME TRUE: THE GI BILL AND THE MAKING OF MODERN AMERICA 7 (1996) ("The GI Bill was the catalyst creating our present postcapitalist society"); PETER F. DRUCKER, POST-CAPITALIST SOCIETY 3 (1993) (identifying the G.I. Bill as

something between five and twelve times the capital expended on it in terms of tax revenues alone.²²² While it is difficult to confidently unpack educational benefits from the other benefits of the G.I. Bill, such as subsidized mortgages for housing and low interest business loans,²²³ other indicators suggest that education significantly increases the earning power of the educated person over his or her uneducated peers, including an average increase of nearly \$18,000 in average yearly earning power over the last two decades.²²⁴

On the other hand, the G.I. Bill is challenged on the grounds that its modern educational benefits are insufficient compared to the risks of military service, which fall disproportionately on persons of color.²²⁵ The concern that educational benefits can impair the decisional capacity of emerging adults is also reflected in other lines of scholarship, including the coercion test utilized by the Supreme Court in Establishment Clause which looks both to the age of those subject to a potentially coercive message and the environment in which the exposure takes place.

There is a general concern that high school and college students are more susceptible to religious coercion than older adults, who typically

a transformative event that helped usher in a "shift to the knowledge society[,]" and arguing that perhaps nothing more important occurred in the twentieth century).

222. Steven A. Ramirez, *The Law and Macroeconomics of the New Deal at 70*, 62 MD. L. REV. 515, 558 (2003). "The GI Bill fueled decades of growth through education expenditures that significantly improved the quality of the nation's human capital." *Id.* at 571.

223. *Id.* at 557.

224. Comparing the average income for high school male graduates from 1990-2004 against the average income for a male graduate of a four-year college or university during the same period shows an increase in average income from \$31,039 per year (\$465,583 over 15 years) to \$48,940 per year (\$734,099 over 15 years), a difference of \$17,901. THOMAS D. SNYDE ET AL., *DIGEST OF EDUCATION STATISTICS 2005*, at 624 tbl.378 (2006).

225. See Merrily Davies, *You Can't Be All You Can Be if You Are Dead*, COMMUNITY ALLIANCE (Fresno, Cal.) Apr. 2006, at 15. Of course, the fact that a course of action falls disproportionately upon minority populations does not mean that those populations should be prevented from deciding whether the benefits are worth the risks. As Michele Goodwin writes regarding organ donation, "African Americans are caught in a strange, conflicting matrix, which calls them noble and generous if they surrender organs and blood without compensation, but naïve, unsophisticated, and prone to exploitation and coercion if they are compensated for undergoing a non-therapeutic organ removal. In addition to the racism seemingly inherent in scholarship that casts Blacks as naïve or potentially criminal if they are compensated for sharing organs, the discourse about organ and tissue procurement and allocation regimes also often portrays African Americans as victims rather than recipients or donors." Goodwin, *The Body Markets*, *supra* note 10, at 607. See also WERTHEIMER, *supra* note 200, at 111 (arguing in the realm of surrogate gestation, that "[i]f a woman can reasonably regard surrogacy as improving her overall welfare given that society has unjustly limited her options, it is arguable that it would be adding insult to injury to deny her that opportunity.").

encounter religious messages outside of the academic setting.²²⁶ The Supreme Court has turned to a “coercion test” for violations of the Establishment Clause which looks both to the age of those potentially subject to coercion, and the environment in which they are exposed to a potentially coercive message.²²⁷ Courts have found that college students are “uniquely susceptible to [religious] coercion” when faced with a religious prayer in an academic setting,²²⁸ while participants exposed to prayer in a legislative session were considered “not readily susceptible to ‘religious indoctrination,’ . . . or peer pressure.”²²⁹

Scholars have also argued that athletic scholarships exploit college athletes in a way more likely to harm Black athletes than White athletes,²³⁰ in part because Black athletes are more likely to be funneled into fields that are unlikely to provide sufficient income after graduation.²³¹ These arguments suggest that the disadvantaged background of Black college athletes allow for the exploitation of those athletes. That may be more

226. See Elizabeth B. Halligan, Note, *Coercing Adults?: The Fourth Circuit and the Acceptability of Religious Expression in Government Settings*, 57 S.C. L. REV. 923, 936 (2006) (noting that the Supreme Court’s Establishment Clause jurisprudence has keyed off the age and maturity of those subject to a potentially coercive influence).

227. See *Santa Fe Indep. Sch. Dist. v. Doe*, 530 U.S. 290, 311 (2000) (holding that a student prayer at a school sponsored football game violated the Establishment Clause, in part because such a sporting event was “part of a complete educational experience.”); *Lee v. Weisman*, 505 U.S. 577, 593 (1992) (holding that a prayer offered at a high school graduation violated the Establishment Clause because the school district’s “supervision and control . . . places public pressure, as well as peer pressure, on attending students . . . [which] though subtle and indirect, can be as real as any overt compulsion.”).

228. *Mellen v. Bunting*, 327 F.3d 355, 371-72 (4th Cir. 2003) (finding that supper prayers at a military college violated the Establishment Clause, in part due to the coercive atmosphere of the military college and in part due to the susceptibility of the students to coercion).

229. *Marsh v. Chambers*, 463 U.S. 783, 792 (1983) (holding that a prayer at the start of a legislative session did not violate the Establishment Clause) (citations omitted).

230. Otis B. Grant, *African American College Football Players and the Dilemma of Exploitation, Racism and Education: A Socio-Economic Analysis of Sports Law*, 24 WHITTIER L. REV. 645, 649 (2003) (reporting that while African American college football players “successfully bargained for a free education in exchange for playing football . . . they do not graduate on par with their White counterparts . . . [which] means that on average, most African American players do not benefit from their ‘bargained-for exchange’”).

231. *The False Promise of Black Athletic Scholarships*, 6 J. BLACKS HIGHER EDUC., Winter 1994-1995, at 36, 36-37 (noting that “many [Black] student athletes are enrolled in college simply to play basketball. Many go through the motions of college instruction (often with the complicity of the administration, faculty, and coaching staff) so they will maintain their athletic eligibility. Only 35 percent of black male basketball players on athletic scholarships at NCAA Division I institutions go on to earn a diploma.”).

stereotype than substance.²³² Nevertheless, it would be odd to suggest the correct solution to the exploitation of college athletes is to prevent them from receiving any benefit from the scholarship program, or to require athletes to donate their time and skills without any scholarship benefits at all. If there are concerns about the coercive effects of scholarship benefits, then the experience of college athletes teaches two things. First, the scholarship incentive must provide opportunities for academic success. This suggests that the proposed scholarship program ought not affect admissions to a particular institution, but instead ought to pay for schooling at an institution where the donor was admitted on merit, but would otherwise be unlikely or unable to attend because of cost. Second, there is reason to think the scholarship incentive ought to include academic counseling, and perhaps tutoring, to assure that donors who receive the opportunity for education are equipped to make the most of it.

The aforementioned concerns are due in part to the youth of those who typically consider educational opportunities or are involved in educational institutions.²³³ Some recent scientific data suggests that risk taking behaviors do not peak at the end of adolescence, generally at age eighteen to nineteen,²³⁴ but instead during emerging adulthood.²³⁵ Restrictions on

232. Compare Tommy Craggs, *Where They Come From*, ESPN THE MAGAZINE, Feb. 25, 2008, at 50 (study finding that the childhood home of the average NBA basketball player spent his formative years in a hometown that was medium-sized, middle-class, diverse, and as educated as the United States as a whole), with DARCY FREY, *THE LAST SHOT: CITY STREETS, BASKETBALL DREAMS* 13-15, 22-24, 30, 32 (1994) (documenting the difficult background of four high school students from Coney Island who struggled to meet the academic requirements to play in the NCAA).

233. See, e.g., Sarah M. Lavigne, Comment, *Education Funding in Maine in Light of Zelman and Locke: Too Much Play in the Joints?*, 59 ME. L. REV. 511, 523 n.82 (2007) (noting that some programs allow school voucher funds to go to religious schools so long as the schools agree “not to compel any student attending the private school [by benefit of the voucher program] to profess a specific ideological belief, to pray, or to worship.”) (alteration in original) (citing FLA. STAT. § 229.0537(4)(i) (repealed 2003)); Hanlon, *supra* note 174, at 69-74 (describing the inequitable bargaining power between universities and athletic departments who control athletic scholarships and the athletes who depend on them).

234. Arnett, *supra* note 179, at 476 (“[C]ontemporary scholars generally consider adolescence to begin at age 10 or 11 and to end by age 18 or 19.”).

235. Craig M. Bennett & Abigail A. Baird, *Anatomical Changes in the Emerging Adult Brain: A Voxel-Based Morphometry Study*, 27 HUMAN BRAIN MAPPING 766, 766-67 (2006) (reporting that the brains of college freshmen who have moved at least 100 miles from home to attend college evidence anatomical changes which support the finding that emerging adults continue to mature developmentally between the ages of eighteen and twenty-five); Jerald G. Bachman et al., *Transitions in Drug Use During Late Adolescence and Young Adulthood*, in TRANSITIONS THROUGH ADOLESCENCE: INTERPERSONAL DOMAINS AND CONTEXT 111, 117-18 & fig.5.3 (Julia A. Graber et al. eds., 1996) (reporting on data indicating that rates of binge drinking among reported subjects peak at age twenty-one to twenty-two and do not fall below

certain privileges for those in the emerging adulthood phase—for example, legally purchasing or consuming alcohol, or renting an automobile²³⁶—implies that many individuals between the ages of eighteen and twenty-five are not to be fully vested with the autonomy of decision making that society vests in older persons.

Decisional capacity is not tied to a hard and fast age limit. As current science recognizes, some individuals evidence the ability to make rational decisions and take responsibility for their health and welfare at an earlier age than others.²³⁷ In fact, some scholarship suggests that while adolescents in their late teens do not make risk assessments in the way that an adult would,²³⁸ they are benefited by opportunities to weigh information and make decisions for themselves.²³⁹

pre-adolescent levels until age twenty-eight to twenty-nine). One possible explanation for the spike in binge drinking at the age of twenty-one is that alcohol is first legally available to emerging adults when they turn twenty-one. While binge drinking is certainly a risky behavior, perhaps it shows a certain amount of foresight that some young adults wait until they are legally of age before they engage in such behavior.

236. Arthur J. Matas, *Ethics of Paid Living-Unrelated Donation: The Case for a Regulated System of Kidney Sales*, in *LIVING DONOR TRANSPLANTATION*, 418, 424-25 (Henkie P. Tan et al. eds., 2007).

237. See Sandra Hoffmann, *Since Children Are Not Little Adults—Socially—What's an Environmental Economist to Do?*, 17 *DUKE ENV. L. & POL'Y F.* 209, 222-25 (2007) (discussing that some children learn to assess expected outcomes earlier than other children).

238. Thomas Grisso, *What We Know About Youths' Capacities as Trial Defendants*, in *YOUTH ON TRIAL: A DEVELOPMENTAL PERSPECTIVE ON JUVENILE JUSTICE* 139, 161-62 (Thomas Grisso & Robert G. Schwartz eds., 2003) (reporting on recent studies indicating that adolescents may differ from adults in underestimating the possible losses of their behavior, and that young adolescents, or adolescents with low IQ scores will tend to weigh short term benefits more heavily than long term benefits).

239. Paul Arshagouni, *"But I'm an Adult Now . . . Sort Of": Adolescent Consent in Health Care Decision-Making and the Adolescent Brain*, 9 *J. HEALTH CARE L. & POL'Y* 315, 323-24 (2006) (suggesting that an inability to project future circumstances might actually militate in favor of expanding the rights of youth to privacy in their medical decisions, and in their rights to consent to medical procedures independent of their parents as a means for fostering responsible behavior and decision making); EUGEN VERHELLEN, *CONVENTION ON THE RIGHTS OF THE CHILD* 27-29 (3d ed., 2000) (arguing that observation of children, especially in war-torn or chaotic regions, provides evidence that they are capable of participating as full-fledged members of society with rights and freedoms, and that their capacity for self-determination should be recognized because that will allow them the opportunity to develop that capacity); Donald L. Beschle, *The Juvenile Justice Counterrevolution: Responding to Cognitive Dissonance in the Law's View of the Decision-Making Capacity of Minors*, 48 *EMORY L.J.* 65, 96, 101-02 (1999) (noting that the social science data of the day provided at least provisional support for the proposition that adolescents aged seventeen and above possess the same capacity to make significant life decisions as adults, while recognizing they might reach different decisions than the adults).

One recent brain morphometry study demonstrated measurable changes in the brain structure of college freshmen who moved at least 100 miles away from home to attend college.²⁴⁰ The changes occurred in parts of the brain associated with the ability to “integrate diverse sensory components for use in higher-order [decisionmaking] processes.”²⁴¹ The study was inconclusive regarding whether the significant changes in the environment triggered the growth of brain structure, or whether the growth was “a result of a predetermined neurodevelopmental trajectory.”²⁴² Some research indicates that changes in environment alter brain structures,²⁴³ which might indicate that undertaking new experiences and making difficult decisions increases the capacity to make difficult decisions.²⁴⁴ Other scholars have suggested that because “impulsive behavior and risk-taking associated with late adolescence does not begin to stabilize until the mid-twenties,”²⁴⁵ both marriage and the decision to start a family might be contraindicated until the period of emerging adolescence has ended.²⁴⁶

Science is thus inconclusive on the ability of emerging adults to correctly ascertain risk, but the law is fairly uniform in presuming decisional capacity on the part of those who reach the age of majority, and in some circumstances, even younger. Mature-minor statutes indicate that even adolescents younger than eighteen should be, and are, allowed to make medical decisions for themselves when they evidence sufficient capacity. Some states adopt a rule of sevens, treating minors under seven years of age as having no capacity to consent, minors between seven and fourteen as under a rebuttable presumption of no capacity, and minors between fourteen and eighteen as under a rebuttable presumption of capacity.²⁴⁷ In

240. Bennett & Baird, *supra* note 235, at 767.

241. *Id.* at 774.

242. *Id.* at 775.

243. *Id.* at 775 (citing Sara L. Bengtsson et al., *Extensive Piano Practicing Has Regionally Specific Effects on White Matter Development*, 8 NAT. NEUROSCIENCE 1148 *passim* (2005) (explaining that musical training at an early age is an important factor behind the development of high-level abilities in other domains)); Bogdan Draganski et al., *Changes in Grey Matter Induced by Training*, 427 NATURE 311, 311 (2004) (reporting findings that indicate that “learning-induced cortical plasticity is also reflected at a structural level.”); Eleanor A. Maguire et al., *Navigation-Related Structural Change in the Hippocampi of Taxi Drivers*, 97 PROC. NAT’L ACAD. SCI. U.S.A. 4398, 4399 (2000) (noting an increase in gray matter volume in the brains of taxi drivers).

244. VERHELLEN, *supra* note 239, at 27-29.

245. Naomi Cahn & June Carbone, *Red Families V. Blue Families* 4 (The Geo. Wash. Univ. Law Sch. Pub. Law & Legal Theory Working Paper No. 343, Aug. 16, 2007), at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1008544 (last visited Apr. 9, 2009).

246. *Id.*

247. See, e.g., *Miller ex rel. Miller v. Dacus*, 231 S.W.3d 903, 908 (Tenn. 2007) (finding that a minor aged seventeen years, seven months was a “mature minor” who could provide

most jurisdictions, a minor may be granted a “mature minor” exception to the requirement that an adult approve medical treatment for a minor child.²⁴⁸ As Rhonda Gay Hartman has noted, the “paramount consideration [of state legislatures] in enacting these state statutes has been increasing recognition of adolescent decisional ability in light of the opinions of health care professionals who deem it appropriate to treat an adolescent in the absence of parental or guardian authority.”²⁴⁹

State marriage laws also recognize the capacity of emerging adults to make critical decisions influencing their futures. Every state but one²⁵⁰ allows adults of eighteen years of age to obtain a marriage license without parental consent or court approval.²⁵¹ Some of those states also allow minors under the age of eighteen to obtain a marriage license without parental consent with approval of a court.²⁵²

The law allows youth of eighteen years to volunteer for military service, to vote, to drive, to stand trial as an adult, and to be considered independent from their parents without any intervention of the state. Taking those capacities as data points, it appears that eighteen is old enough to

informed consent to a medical procedure, and to whom medical treatment may be provided without obtaining parental consent) (citing *Cardwell v. Bechtol*, 724 S.W.2d 739, 755 (Tenn. 1987)).

248. *Cardwell*, 724 S.W.2d at 748, 755 (noting that under Tennessee law, “the capacity [of a minor] to consent to medical treatment depends upon the age, ability, experience, education, training, and degree of maturity or judgment obtained by the minor, . . . the conduct and demeanor of the minor at the time of the incident involved . . . [as well as] the nature of the treatment and its risks or probable consequences, and the minor’s ability to appreciate the risks and consequences”); *AHRONHEIM ET AL.*, *supra* note 183, at 32 (reporting that the mature minor exception grants decision making authority at around age fifteen, based on fact-specific circumstances).

249. Hartman, *supra* note 142, at 1311.

250. Mississippi is the only state that does not automatically allow eighteen year olds to obtain a marriage license. MISS. CODE ANN. § 93-1-5(a) (2008) requires that if the female applicant for a marriage license is under the age of twenty-one and a resident of the state, then the application must be made in the county where the applicant resides, and must include the names and addresses of the female applicant’s parents or next of kin. *Id.* In addition, the application is subject to a three-day waiting period, which can be waived by a judge. *Id.* § 93-1-5(b). The county clerk is also required by law to inform parents if either party “appears from the evidence to be under twenty-one (21) years of age” *Id.*

251. NATIONAL SURVEY OF STATE LAWS 434-38 tbl.29 (Richard A. Leiter ed., 5th ed. 2005) (reporting that in Mississippi, the minimum legal age to marry without parental consent is twenty-one).

252. See, e.g., COLO. REV. STAT. § 14-2-108 (2008) (granting authority to the juvenile court to order the county clerk and the recorder to issue a marriage license to a party aged sixteen or seventeen years even if a parent or guardian has not provided consent, so long as a reasonable effort has been made to notify the parents, and the court “finds that the underage party is capable of assuming the responsibilities of marriage and the marriage would serve his best interests.”).

determine whether donating a kidney is a prudent choice for the donor, especially given evidence that indicates the limited health risk of living donation.²⁵³ This is particularly true when comparing kidney donation to military service, which poses significant risks to soldiers.²⁵⁴ If it is acceptable to let high school students hear a recruitment pitch and enlist when they turn eighteen, it should be acceptable from a risk assessment perspective to allow them to gather information about the risks involved with kidney donation and make a commitment to donate when they turn eighteen. It should be noted that while the current donation regime requires a court order to allow donation from those under the age of eighteen, there is a strong legal presumption that once a donor has reached the age of

253. See R. Pretagostini et al., *Survival in Kidney Transplantation from Living Donors: A Single-Center Experience*, 36 TRANSPLANTATION PROC. 467, 467-68 (2004) (reporting no perioperative mortality among a study of 600 donors); Thiagarajan Ramcharan & Arthur J. Matas, *Long-Term (20–37 Years) Follow-Up of Living Kidney Donors*, 2 AM. J. TRANSPLANTATION 959, 959-60 (2002) (reporting that in a population of 380 living donors still alive at the time of the study, the majority of donors had normal renal function 20-37 years post donation, and of 84 living donors who had since died, only 3 were known to have died of kidney failure); Eric M. Johnson et al., *Long-Term Follow-Up of Living Kidney Donors: Quality of Life After Donation*, 67 TRANSPLANTATION 717, 717-19 (1999) (reporting that in a survey of 524 living donors whose surgery occurred at the University of Minnesota between 1984 and 1996, the majority of donors reported good quality of life, that donation was little or no financial burden, that problems with health insurance were not stressful or only a little stressful, and that they did not regret donating); R. Saran et al., *Long-Term Follow-Up of Kidney Donors: A Longitudinal Study*, 12 NEPHROLOGY DIALYSIS TRANSPLANTATION 1615, 1616, 1620 (1997) (finding among a group of 47 kidney donors that renal function appears relatively well preserved 20 to 30 years after donation). Eugene Volokh reports that living donors face approximately the same yearly risk of death as those working as long-haul truck drivers. Volokh, *supra* note 213, at 1841-42. See also *Strunk v. Strunk*, 445 S.W.2d 145, 149 (Ky. Ct. App. 1969) (noting that upon donating a kidney, the statistical life expectancy of a healthy 35 year old adult drops from 99.3% to 99.1% during the next 5 succeeding years, equivalent to the risk “incurred by driving a car for 16 miles every working day . . .”) (internal citation omitted). Note as well that the numbers reported in *Strunk* were from 1969. Medical care for donors has significantly improved in the past forty years.

254. See, e.g., GULF WAR AND HEALTH: PHYSIOLOGIC, PSYCHOLOGIC, AND PSYCHOSOCIAL EFFECTS OF DEPLOYMENT-RELATED STRESS 248-58 (Inst. of Med., Nat. Acad. ed., 6th ed. 2008) (cataloguing the health risks accompanying military service); *Military Service Doubles Suicide Risk*, SCIENCE DAILY, June 12, 2007, at www.sciencedaily.com/releases/2007/06/070612075148.htm (last visited Apr. 9, 2009) (reporting that the suicide rate of soldiers who saw combat is twice that of the general population); *contra* Samuel H. Preston & Emily Buzzell, *Service in Iraq: Just How Risky?*, WASH. POST, Aug. 26, 2006, at A21 (noting that while the death rate for U.S. men aged 18-39 in 2003 was 1.53 per 1,000 person years—39% of which was due to the deaths of troops in Iraq (3.92 deaths per 1,000 person years)—that number is less than the risk of death for Black youth in Philadelphia (4.37 per 1,000 person years in 2002)).

majority,²⁵⁵ "specific evidence of incapacity is required to call into question an adult's empowerment to make his or her own decisions."²⁵⁶ The scientific evidence does not sufficiently call into question the decisional capacity of donors who have reached the age of majority, so as a legal matter, the presumption of capacity for donors over the age of eighteen should hold true.²⁵⁷

If further studies solidify the intuition that emerging adults lack decisional capacity, the proposed scholarship incentive could be restricted to more mature students, perhaps providing scholarship incentives for law, medical, business, or other graduate students.²⁵⁸ Like an undergraduate scholarship program, a graduate scholarship incentive could provide large benefits for a student who is concerned about the ability to pay for the loans accrued at high end schools.²⁵⁹ Such an orientation may not provide enough incentive

255. See, e.g., Vivek Sharma et al., *Pediatric Living-Donor Kidney Transplantation*, in *LIVING DONOR TRANSPLANTATION* 149, 151 (Henkie P. Tan et al. eds., 2007) (noting that in exceptional cases, a court order can allow a donation to go forward when it involves a donor under the age of eighteen).

256. AHRONHEIM ET AL., *supra* note 183, at 29.

257. It should be noted that individual OPOs have differing policies for the acceptable minimum age of nondirected donors. For example, the transplant center at the University of Minnesota rejects nondirected donors who are younger than twenty-one. Cheryl L. Jacobs et al., *Twenty-Two Nondirected Kidney Donors: An Update on a Single Center's Experience*, 4 *AM. J. TRANSPLANTATION* 1110, 1111 (2004) (reporting that the center rejected 3 potential nondirected donors out of 360 interested callers because they were under the age of 21). The center explained the decision to raise its minimum age from 18 to 21, noting that "[t]he few inquirers who were under 21 years had either voiced parental concerns about donating or avoided telling their parents altogether for fear of their disapproval or anger. Therefore, we were concerned about possible family stress, lack of support after donation, and donor vulnerability during recovery." *Id.* at 1114.

258. Stanford University's Career Development Center reports that the average age of a first-year law student is twenty-four. Stanford University Career Development Center, Law Overview, at <http://cardinalcareers.stanford.edu/law/> (last visited Apr. 9, 2009). The average age of first year business students "at the top business schools" is twenty-seven. Yahoo! Education, Admissions to Business School, at <http://education.yahoo.com/college/essentials/articles/biz/bschool-admissions.html> (last visited Apr. 9, 2009). The ages of the 2008 incoming class at Harvard Medical School ranged from twenty-one to thirty-six. Harvard Medical School, Admissions FAQs, at <http://hms.harvard.edu/admissions/default.asp?page=admissions> (last visited Apr. 9, 2009).

259. Medical school graduates carry an average post-graduation debt of \$130,571. Editorial, *Repair Student Loan Repayment Law: A Federal Legislative Change in How Medical School Graduates Repay Their Loans Leaves Residents in a Financial Pinch*, *AM. MED. NEWS*, Nov. 19, 2007, at www.ama-assn.org/amednews/2007/11/19/edsa1119.htm (last visited Apr. 9, 2009). First year associate lawyers typically bear a debt from undergraduate and law school of \$80,000. *Am. Bar Ass'n, 2006 Legislative Priorities: Student Loan Forgiveness*, at www.abanet.org/poladv/priorities/student_loan.html (last visited Apr. 9, 2009) [hereinafter Student Loan Forgiveness].

however, for many students at top tier legal, medical, and business schools, where starting salaries after graduation have historically been sufficient to quickly pay down loans. In the field of law, for instance, compensation for starting attorneys at some blue chip law firms is \$160,000, and partner pay can top \$1 million.²⁶⁰ When contrasted with the salary range of the typical government lawyer (\$43,300 to \$46,300 in 2006) or legal services attorney (\$36,000 in 2006),²⁶¹ it is obvious that the scholarship incentive highlights a troubling trend and might raise questions of coercion.²⁶² If attorneys committed to public interest work are most likely to take advantage of the scholarship incentive to avoid crushing loan repayments, then the scholarship incentive would be vulnerable to the criticism that it enables lawyers to engage in public interest law, but only if those public minded lawyers are literally willing to “sell a kidney” to do it. There would also be a concern that limiting participation to students in professional programs might restrict the potential donor population to such an extent that it could not meet the need for transplantable kidneys.²⁶³

3. The scholarship incentive encourages informed consent

The proposed scholarship incentive differs from a cash-for-kidneys regime sufficiently to limit the potential harms caused by an unrestricted market regime. First, the scholarship program is a system of delayed compensation, providing a benefit that cannot be transferred into quick cash, but which is more likely than a simple cash donation to provide long-term benefits to donors. Second, while there are concerns that college-aged individuals are particularly susceptible to financial coercion and to misapprehend the risks involved with various courses of action, the proposed scholarship can be structured to respond to some of those concerns.

Donating a kidney is not like getting a tattoo or maxing out one’s credit cards. The informed consent procedures currently in place, combined with the time necessary to match donors with recipients,²⁶⁴ provides a certain

260. Lisa Lerer, *The Scourge of the Billable Hour: Could Law-Firm Clients Finally Kill It Off?*, SLATE, Jan. 2, 2008, at www.slate.com/id/2180420/fr/rss/ (last visited Apr. 9, 2009).

261. Charles Toutant, *Public Interest Law Jobs Still Paying Peanuts*, LAW.COM, Sept. 12, 2006, at www.law.com/jsp/law/LawArticleFriendly.jsp?id=1157978115780 (last visited Apr. 9, 2009).

262. The ABA notes that “[o]nly those students with debt burdens [in the \$40,000 range] tend to enter public interest positions.” Student Loan Forgiveness, *supra* note 259.

263. See *supra* note 98 and accompanying text.

264. The Kidney Foundation of Canada suggests that the process to determine if an individual can donate a kidney takes between three to six months. The Kidney Found. of Canada, *Living Kidney Donation—Frequently Asked Questions*, at www.kidneyfoundation.ab.ca/Be_Involved/FAQ%20Live%20Donation.htm (last visited Apr. 9, 2008). The transplant

check on impulse decisions. For example, in one reported study, the University of Minnesota screened 142 nondirected donors for transplant, rejecting 23 donors (16%) for medical reasons and another 15 (11%) for nonmedical reasons.²⁶⁵ In fact, unlike the gentleman applying ink at the local tattoo parlor, medical professionals tend to be overcautious in verifying that the donor is truly willing to donate—going so far as to provide potential recipients with last minute excuses of incompatibility if the donor gets cold feet,²⁶⁶ or reject adult donors who seem too media focused, or whose immediate family is concerned that the donation is not fully voluntary.²⁶⁷

There are risks that the proposed scholarship program might prey on underprivileged populations, as critics claim military recruiting preys on vulnerable high school populations.²⁶⁸ Military recruiters are effectively in the position of counseling high school students about a life-altering

center at the University of Florida Shands Hospital suggests that it takes four to eight weeks to match a donor with a recipient. UF & Shands Jacksonville Transplantation, Kidney Transplantation, at <http://jax.shands.org/hs/transplantation/services.asp#kidney> (last visited Apr. 9, 2009).

265. Adams, *supra* note 128, at 585 (citing C. Jacobs et al., *Nondirected Donation: Who Volunteers? Who is Rejected?*, 1 AM. J. TRANSPLANTATION 249 (2001)). See also L. Kranenburg et al., *The Psychological Evaluation of Samaritan Kidney Donors: A Systematic Review*, 38 PSYCHOL. MED. 177, 177-78 (2007) (reporting that psychological evaluation is a standard part of the donor evaluation procedure). A national conference of the transplantation community held in 2001 defined several categories of “unacceptable donor expectations” about transplantation, including the desire for media attention, a desire by the donor to select the recipient by gender, race, or ethnicity, or a desired involvement in the recipient’s life after donation. Adams, *supra* note 128, at 585.

266. Joel D. Kallich & Jon F. Merz, *The Transplant Imperative: Protecting Living Donors from the Pressure to Donate*, 20 J. CORP. L. 139, 152 (1995) (reporting that physicians “[o]ccasionally . . . provide a technical excuse (such as a poor match) for potential donors expressing their desires not to proceed with the act.”); Arthur L. Caplan, *Am I My Brother’s Keeper?*, 27 SUFFOLK U. L. REV. 1195, 1205 (1993) (arguing that for consent to be valid, the donor must be able to withdraw consent, meaning that “physicians seeking consent must be willing to provide a ‘cover story’ or some form of ‘medical excuse’ for the prospective donor should the donor refuse or withdraw their consent.”); Michael J. Saks, *Social Psychological Perspectives on the Problem of Consent*, in CHILDREN’S COMPETENCE TO CONSENT 41, 49 (Gary B. Melton et al. eds., 1983) (reporting that doctors often use the excuse of incompatibility to shield a prospective donor from family pressure if the intended donor chooses not to donate).

267. Parents of a potential donor, a member of the religious group called the Jesus Christians, contacted North American transplant centers and raised questions about the donor’s ability to provide informed consent to the kidney procedure. A hospital in Toronto where the donor’s transplant was scheduled rejected him as a donor on the grounds that he was “motivated by the desire for publicity . . . not by altruism.” Meckler, *supra* note 127.

268. Davies, *supra* note 225, at 15 (reporting that recruiters provide aggressive sales pitches regarding the educational benefits from military service while underselling the possibility of going to war).

decision, and critics argue that they provide less than complete information in part because they are so keen to recruit. However, there is no reason to think that recruiting for the scholarship program need be as aggressive as military recruiting is perceived to be. Indeed, it would be a breach of medical ethics to fail to provide a prospective donor with the information necessary to make an informed decision.²⁶⁹ At minimum, the scholarship program should put a firm cap of eighteen as the minimum age to donate a kidney. This should ameliorate some of the inherent risks regarding the arguably limited judgment of potential donors. In addition, all information necessary to meet informed consent requirements under rules of medical ethics should be provided to prospective donors after they reach a minimum age of eighteen. One additional safeguard for donors would be to provide the prospective donor with her own doctor, unassociated with the transplant team, to avoid any potential unconscious pressure on the part of the surgeon to coerce consent.

V. STATUTORY OBSTACLES TO THE SCHOLARSHIP PROGRAM

The final obstacle to the scholarship incentive is statutory: the incentive is against the law under the National Organ Transplantation Act (NOTA) and the Uniform Anatomical Gift Act (UAGA). Specifically, a scholarship is likely valuable consideration for a donated kidney donation creates a valuable consideration, and it is a felony under NOTA to offer or receive anything of value in exchange for a kidney. While this article has argued that the scholarship program is likely to be palatable as a means of providing financial incentives for organ donation, as well as effective at increasing the incidence of living donation, there are statutory provisions that make the program difficult to realize. NOTA prohibits the transfer of any organ, including kidneys,²⁷⁰ “for valuable consideration for use in human transplantation if the transfer affects interstate commerce.”²⁷¹ Any kidney shipped across state lines would be subject to that prohibition. In addition, the transfer of kidneys through intrastate activity is governed by the UAGA, parts of which have been adopted in one form or another by all fifty

269. Mark Unruh et al., *Evaluation: Specific Issues for Living-Donor Kidney Transplantation*, in *LIVING DONOR TRANSPLANTATION* 33, 45 (Henkie P. Tan et al. eds., 2007) (discussing the various health risks implicated by living donation of a kidney, and asserting that both medical professionals and the prospective donor have the responsibility to insure that the donor has “an acceptable risk profile”); Adams, *supra* note 128, at 582 (“Transplant centers that accept [nondirected donors] should document an informed consent process that details donor risks, assures donor safety, and determines that the goals and expectations of the [nondirected donor] and the recipient can be realized.”).

270. 42 U.S.C. § 274e (2000).

271. 42 U.S.C. § 274e(a) (2000).

states,²⁷² which prohibits “a person that for valuable consideration knowingly purchases or sells a part for transplantation or therapy if removal of a part from an individual is intended to occur after the individual’s death”.²⁷³ Both statutes provide criminal penalties for the transfer of kidneys for valuable consideration.²⁷⁴

These provisions create a substantial obstacle to the proposed scholarship program because as a statutory matter, scholarships are considered valuable consideration if there is a quid pro quo involved,²⁷⁵ i.e., “any amount received which represents payment for teaching, research, or other services by the student required as a condition for receiving the qualified scholarship”.²⁷⁶ Altering the scholarship plan to a repayment or reimbursement of student loans would not correct this problem, as they, too, are considered taxable income, or valuable consideration,²⁷⁷ more a bargained-for exchange than a no-strings attached grant.²⁷⁸ Even third-party payments would provide no relief.²⁷⁹

Thus, under the current statutory framework, living donors would be liable for fines and jail time if they accepted a scholarship or loan forgiveness in return for donating a kidney, and any organization offering such a scholarship or loan forgiveness would also be criminally liable.

There is, however, an exception to the rule that a scholarship is always valuable consideration and taxable income whenever there is a quid pro quo involved. As discussed in Part III.C, *supra*, athletic scholarships are treated by the IRS as if there were no quid pro quo involved in playing college athletics.²⁸⁰ It is unclear why the IRS persists in embracing the legal

272. 22A AM. JUR. 2D *Dead Bodies to Declaratory Judgments* § 86 (2003).

273. REV. UNIF. ANATOMICAL GIFT ACT § 16 (2008).

274. 42 U.S.C. § 274e(b) (2000); REV. UNIF. ANATOMICAL GIFT ACT § 16(a) (2008).

275. The Supreme Court embraced the “quid pro quo” test as the correct metric to measure whether a scholarship should be treated as tax-exempt, or instead as taxable income. *Bingler v. Johnson*, 394 U.S. 741, 757-58 (1969) (finding that a grant given to a taxpayer by the taxpayer’s employer to enable research and writing, where the taxpayers was obligated to return to the employer after the research period, is a bargained-for exchange rather than a no-strings attached grant and thus properly taxable).

276. I.R.C. § 117(c)(1) (2000 & Supp. IV 2005).

277. I.R.C. § 108(f)(3) (2000). There are exceptions to treating educational loan forgiveness as income, but those exceptions would not apply to the proposed scholarship incentive.

278. *Bingler*, 394 U.S. at 757-58.

279. Joseph M. Dodge, *Scholarships Under the Income Tax*, 46 TAX LAW. 697, 725 (1993) (“[C]ompensation received directly or indirectly from third parties (as might occur in the case of internships) would on no account be excluded under section 117.”).

280. See *supra* notes 174-178 and accompanying text. Rev. Rul. 77-263, 1977-2 states that athletic scholarships are not taxable income because the university requires no particular activity of any of its scholarship recipients. Although students who receive athletic scholarships

fiction that athletic scholarships are unconnected to any services required from the recipient-athlete, but perhaps the Service does so because there would be no other way to preserve the tax-exempt status of athletic scholarships under the quid pro quo test. Such a determination provides a legal opening for the proposed scholarship incentive: sometimes a scholarship granted as part of a bargained-for exchange is treated as a tax-exempt gift instead of valuable consideration. This is a weak limb on which to hang the hopes of the proposed scholarship incentive, but it does provide a framework for discussion. If fielding a basketball team, generating revenue, and recruiting for a university is a goal sufficient to justify special tax-exempt treatment of a bargained-for exchange, then providing a scholarship that will increase the needed supply of kidneys, thereby extending the lives of recipients and improving the quality of those lives, might merit the same type of special treatment.²⁸¹

Tax scholar Joseph M. Dodge suggests that where a scholarship includes valuable consideration—i.e., a graduate student teaching courses for the university—the value of the services provided is correctly taxable, and scholarship value in excess of those services should be tax-exempt.²⁸² Consider a graduate student who received a \$10,000 scholarship, and was required to teach a course as a condition for receiving the scholarship. If other teachers were paid \$4,000 for the same work, then \$4,000 of the graduate student's scholarship would be taxable income, and the remaining \$6,000 would be tax exempt. Applying the same logic to the proposed kidney scholarship incentive, kidneys cannot be sold on the open market, and the transplantation industry treats them as if they had a value of \$0. Thus, the entire value of the scholarship award should be tax-exempt because there is no value in the service provided—donating a kidney. Unlike teaching at the university, there would be no valuable proxy for the kidney, as it cannot be sold or even overtly assigned value when transferred from one entity in the procurement process to another. This argument is a sleight-of-hand of sorts, given that the thrust of this article is to argue that the donation of a kidney is properly worth the value of a college education

do so because of their special abilities in a particular sport and are expected to participate in the sport, the scholarship is not cancelled in the event the student cannot participate and the student is not required to engage in any other activities in lieu of participating in the sport.

281. Indeed, Michele Goodwin argues for a waiver of the criminal sanctions in NOTA, in order to facilitate attempts by states to work out a successful program for partial commodification. Goodwin, *The Body Market*, *supra* note 10, at 633. Such a waiver would allow states to try out the scholarship incentive proposed in this article. Part II, *supra* provides the justification for allowing the attempt.

282. Dodge, *supra* note 279, at 724. Dodge proposes a hypothetical where the graduate student is provided with a \$10,000 scholarship by the university. As part of the qualification for the scholarship, the student teaches courses for the university. *Id.*

to the donor, to the party paying for the recipient's dialysis, and perhaps to society at large. But so long as the structure of organ procurement laws maintains the legal fiction that there can be no market value for a donated organ, the tax laws which would otherwise treat the scholarship received as a bargained-for exchange for a donated kidney might justify an analogous legal fiction to shield the scholarship incentive from liability under NOTA and the UAGA.

VI. CONCLUSION

This article provides an opening volley in favor of a scholarship program to stimulate the living donation of kidneys. There remains work to be done in this area. A more focused study on the rhetorical function of scholarship benefits, as well as an empirical study of how a potential scholarship incentive would be received is necessary. The discussion of the potential coercive effect of scholarships is also nascent, and empirical work in that area would be exceedingly valuable. Nevertheless, I am optimistic that a scholarship regime could safely negotiate the space between altruistic symbolism and economic reality, and effect a positive, lasting change in both the lives of those waiting for kidneys and those looking for educational opportunities.